MEETING

STATE OF CALIFORNIA

CALIFORNIA PERFORMANCE REVIEW COMMISSION

HEALTH AND HUMAN SERVICES PUBLIC HEARING

PRICE CENTER

BALLROOM AB

UNIVERSITY OF CALIFORNIA, SAN DIEGO

9500 GILMAN DRIVE

LA JOLLA, CALIFORNIA

FRIDAY, AUGUST 20, 2004

10:00 A.M.

APPEARANCES

UNIVERSITY OF CALIFORNIA, SAN DIEGO

Maryanne Fox, Chancellor

COMMISSION MEMBERS

Bill Hauck, Co-Chairperson
President, CA Business Roundtable

Joanne Kozberg, Co-Chairperson
Partner, CA Strategies

Patricia Bates, Assembly Member
California State Legislature

Jess "Jay" Benton, Executive Vice President
ABM Industries

Dale Bonner, Partner
Epstein Becker & Green, P.C.

James Canales, President & CEO
The James Irvine Foundation

Mike Carona, Sheriff
Orange County

Patricia Dando, Vice-Mayor
City of San Jose

David Davenport, Distinguished Professor
Pepperdine University

Denise Ducheny, Senator
California State Legislature

APPEARANCES (CONT.)

COMMISSION MEMBERS (CONT.)

Joel Fox, President
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Steve Frates, Ph.D.
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Russ Gould, President
The Gould Group

Irene M. Ibarra, Executive Vice President
The California Endowment

J.J. Jelincic, President
CA State Employees Association

Steve Olsen, Vice Chancellor
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Beverly O'Neill, Mayor
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Peter Taylor, Managing Director
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HEALTH AND HUMAN SERVICES DELIVERY PANEL

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Representative, California Council of Local Health Officers

Sam Karp, Director
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Barbara Kondylis, County Supervisor, Solano County
Representative, California State Association of Counties

APPEARANCES (CONT.)

HEALTH AND HUMAN SERVICES DELIVERY PANEL (CONT.)

Will Lightbourne, Director
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President, County Welfare Directors Association
of California

Stephen J. Maulhardt, Executive Vice President
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Alcohol and Drug Program Executives

Jim Mayer, Executive Director
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Dan Souza, LCSW
Director, Stanislaus County Behavioral Health
and Recovery Services
Governing Board Member, California Mental Health
Directors Association

HEALTH AND HUMAN SERVICES ADVOCATES PANEL

Kevin Aslanian, Executive Director
Coalition of California Welfare Rights
Organizations, Inc.

Mike Herald, Legislative Advocate,
Western Center on Law and Poverty

Marilyn Holle, Senior Attorney,
Protection and Advocacy, Inc.

Peter Mendoza, Chair
State Council on Developmental Disabilities

Carole Shauffer, Executive Director
Youth Law Center

Catherine Teare, Director of Policy
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APPEARANCES (CONT.)

HEALTH AND HUMAN SERVICES ADVOCATES PANEL (CONT.)

Debra M. Ward, M.P.H., Deputy Director
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Lucien Wulsin, Jr., Project Director
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HEALTH AND HUMAN SERVICES PROVIDER PANEL

Steve A. Escoboza, President and CEO
Healthcare Association of San Diego and Imperial Counties

Elia V. Gallardo, Director of Government Affairs
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STAFF

Chon Gutierrez, Co-Executive Director
California Performance Review

Terri Parker, Team Leader
CPR Health and Human Services Team

Bob Sertich, Team Leader
CPR Health and Human Services Team

I N D E X

I N D E X (CONT.)

I N D E X (CONT.)

I N D E X (CONT.)

P R O C E E D I N G S

CHANCELLOR FOX: I'm Maryanne Fox, the Chancellor of the University of California at San Diego, and on behalf of the students, the faculty, and the staff of UCSD let me welcome you to our campus and to this important hearing.

It's my privilege to greet you in this new home because this is my first week as your Chancellor, having just left the East Coast, from North Carolina.

I want to tell you, on behalf of everyone, how pleased UCSD is to provide the forum for this important event.

This is the second in a series of five statewide hearings on the Governor's California Performance Review, by which citizens will learn more about healthcare recommendations set forth by the distinguished Commission members, who have worked so hard to complete this formidable task.

Several witnesses, who are knowledgeable about this field, will offer their testimony today, to the report and to the discussion, as it evolves, and we're grateful, indeed, for their involvement.

Perhaps most importantly, today's hearing will provide an opportunity for public and community to provide input on the Performance Review process, because that input is indeed very critical for evaluating and holding

accountable the success of this venture.

We're especially proud to host this event because it converges on our own mission at the University of California and, of course, here at UCSD as well, by the emphasis on research, on education and on public service.

We indeed support the principles of institutional reform and we have a campus-wide focus on increasing efficiency and accountability in all parts of our interactions, including performance.

In fact, over the last two years UCSD has provided leadership for a UC-wide initiative to develop what is called a "New Business Architecture" for the entire University system.

And as a proponent of this New Business Architecture, UCSD was the first University campus to develop a comprehensive web business portal that streamlined many costly and bureaucratic business processes.

That model has been recognized nationally and is not emulated in many of our peer institutions across the nation.

UCSD has also been at the forefront of performance assessment in higher education and, in fact, is the only University in the world that has been inducted into what's called the Balanced Scorecard Hall of Fame.

This is a national program that recognizes

innovative business approaches creating, on the basis of our performance assessment model, means by which campus business practices can be facilitated and improved.

So given this background, you can imagine how pleased we are to welcome all of you here and to thank you for your participation.

Let me close these remarks by recognizing and thanking three visionary State leaders who have made this forum possible. They are Governor Arnold Schwarzenegger, who was kind enough to include UCSD in the process; UC Regent Joanne Kozberg, who Chaired the Commission; and State Senator Denise Ducheny, one of San Diego's own, who sat on the Commission and is here with us today.

So we welcome all of you, we thank you for your participation, we look forward to working with you as the recommendations evolve from this Committee, and as this important process continues.

So without delay, let me present to you, University of California Regent Joanne Kozberg, who will chair the subsequent activities. Joanne, thank you for being here.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you, Chancellor.

(Applause.)

COMMISSION CO-CHAIRPERSON KOZBERG: We feel very

fortunate to have added you to the luster of the Chancellors of the University of California System. Thank you.

Bill Hauck, the Co-Chair of this Commission, will be joining us shortly, he had a meeting that he had pre-committed to.

(Audience feedback.)

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. Can you hear me now? Thank you.

Bill Hauck, the Co-Chair of the Commission will be joining us later in the morning.

But it is my pleasure to welcome all of you and tell you how pleased we are to be here on the UC San Diego campus.

As you heard, there were 275 very talented, insightful State employees who put together the California Performance Review. We are not those talented, insightful, 275 people. We are the next phase.

Governor Schwarzenegger has tasked this Commission with going around the State to hear diverse opinions from the citizens and experts on these recommendations, so that we can add further clarity, if it is necessary, and to hear how they approached their mission.

We are very happy to be here. We will also be moving north in the State so that we can hear other opinions on today's subject, which is the Health and Human Services

part of the report.

A few housekeeping notes, the administrative details. There is a sign-up sheet for those who wish to give public testimony later, and that is right out here, right behind the exit sign.

Also, public testimony will be no more than three minutes per person. We have received a number of written forms of testimony, and I'd like to tell all of you that that will be put into the transcript. Do not feel that if you're duplicating information that it will not be heard. We will be reading all of the information, it will go into the transcript. But you do not have to stand up and give testimony if you feel someone else has adequately represented your opinion.

I would like to tell you that the following people have already submitted written testimony; the American Heart Association, Western States Affiliate, Terry Bott, California Alliance of Child and Family Services, California Alternative Payment Program Association, California Association of Area Agencies on Aging, California Budget Project, California Commission on Aging, California Nurses Association, California PAN Ethnic Health Network, Children's Law Center of Los Angeles, the County Alcohol and Drug Program Administrators Association of California, Fight Crime Invest in Kids. Leland Stu Hanson, a disabled retiree

from the Los Angeles School District. Cynthia Huckelberry, RNMA. The Latino Coalition for a Healthy California, Maternal and Child Health Access, and the Regional Center of Orange County.

We thank you all for your testimony.

May I also remind all of you at this time to turn off your cell phones, and that includes us, on the Commission.

There are, also, a limited number of written testimonies that have been provided, and also to let the Commissioners know that this packet sitting before you is testimony that applies to the last hearing that we had, on Infrastructure.

With that, I would like to introduce Chon Gutierrez, Co-Director of CPR, to review the CPR process.

CO-DIRECTOR GUTIERREZ: Thank you, Chairman Kozberg. It's a pleasure to be here with you this morning. Recognizing your schedule, I'm going to give you a context of the CPR process that we went through since February of this year, and I'm going to do that quickly.

The CPR process, as was already stated, was created by Governor Schwarzenegger's Executive Order dated February 10th, where he asked us to do a top to bottom review of State government, to look for ways of making

government more dynamic, to make it better able to perform its services, to be more efficient, to be more effective, and to take advantage of new technologies that will help us deliver the services to the public.

The focus, as I've said, was in making government more efficient and more responsive to the people.

We decided that we would take a two-part process in preparing the document that you are getting a hearing on. The first part is a review of the organizational structure of government, and we chose to use something called the Little Hoover Commission process.

That is a process that is used strictly for governmental reorganization purposes, and one of our volumes is dedicated to organizational structure.

The second part of our review was to look at ways of making government more efficient by looking at the programs that already exist, and making recommendations to have them be able to deliver services more efficiently.

Those recommendations would be addressed through Legislation or would be implemented through Executive Orders of the Governor, if appropriate. So it was a two-part process.

That second part is the some 2,500 pages that are in our document, and it constitutes some 250 subject matters, with a little over 1,300 recommendations.

We made this all happen by putting together 14 teams. Terri Parker, to my right, and Bob Sertich were the Team Leaders for the Health and Human Services Team, a team of 12 people.

TEAM LEADER PARKER: Twenty.

CO-DIRECTOR GUTIERREZ: Twenty people. It was some of the teams were small, in the ten area, others as large as 30 in the corrections area.

The organization was to set up seven teams that looked at functional operations of government and seven teams that looked at horizontal issues.

The functional areas, Health and Human Services, for example, is one and you've already heard about the Infrastructure. Others include Education, Public Safety, Corrections, Resources, and the General Government Function.

In addition to that we had horizontal teams that looked at things such as Information Technology, Procurement, Customer Services, and things of that nature.

Our strategy on the reorganizational structure was to improve customer service. Almost everything we did was to find ways of making government more efficient, improve customer services, and be more responsive to the people.

The process that we used was one of identifying every single recommendation that had been developed over time. We felt, that given the fiscal crisis that California

is facing, that it was an opportunity to look at ideas that have been considered in the past and perhaps not been adopted for a variety of different reasons, to look to other states, to get input from the public. We received over 10,000 contacts in different forms, be it the 800 number, be it the internet, or be it people that called and wanted to come talk to us, or organizations or individuals that the teams, themselves, sought out.

We got the ideas from traditional places in government. We got them from the Little Hoover Commission, we got them from the Legislative Analyst's Office. We went to the Caucuses of the Legislature, asked them for input. We got them from the public. We received well over 2,000 recommendations for things to look at. We consolidated them into 250 issues that are in the book, with over 1,200 recommendations.

We released the document on August 3rd. You've already held one hearing on Infrastructure, this is your second hearing. And we are prepared to be supportive of any future hearings that you may have.

And that, in effect, is the presentation, Madam Chair.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. Would you like to introduce your colleagues at the table?

CO-DIRECTOR GUTIERREZ: I will be very happy,

thank you very much.

To my right is Terri Parker, I'll use the word "long-time" government employee, who has extensive experience and background, both in the program area, and also in the fiscal area. She was Chief Deputy Director of the Department of Finance. She was Undersecretary to the Health and Welfare Agency. She is currently the Executive Officer of the California Housing Finance Agency. And we're very pleased that we were able to get her to give up that key responsibility that she has and come over and be our Team Leader, along with Bob Sertich, to her right.

Bob also is a long-time State employee. I think the three of us probably have a hundred years of State experience sitting here, with Terri with about the least.

Bob, a long-time expert in the area of social services, both in the program area and as a fiscal person. He is currently the Chief Deputy Director of the Department of Social Services.

And they were the two Co-Chairs, and I'm going to turn the mike over to them.

TEAM LEADER PARKER: Good morning, Madam Commissioner, and Commission members. On behalf of Bob and I, we want to thank you for the opportunity to be making our presentation today.

I can tell you, just as a point before we start,

that Bob and I are both committed public servants and have a great love for government and, particularly, health and human services, and the stakeholders, and clients that those programs serve.

So I think we both approached this with a very dedicated team, to essentially offer the best advice, and recommendation, and thought-provoking issues we could for your consideration, and the public's consideration.

When we talk about health and welfare, we think it's always important to put a little bit of a context before we go into the recommendations, specifically, just so people have an idea about the dynamic situation that California is.

And we start out with saying the dynamic mix that we have in California, we are the most racially and ethnic diverse state in the nation, and clearly that has an impact on our health and human service delivery system.

We have 12 percent of the nation's population. This is an interesting fact, too, 4.2 million, or an eighth of our population is over the age of 62. However, 1.7 million or more are between the ages of 45 and 60, than there were in 1990. That's a 43 percent increase.

So although we hate to admit it, we are clearly all aging.

Health and human service, from a fiscal

standpoint, it's $64 billion -- $64 billion proposed by the Governor this year. That's greater than 47 other state's budgets in totality, and 29 percent of the expenditures for State of California programs to serve all of its citizens.

Some specific facts about the Health and Human Services and who we serve. We provide income support to over 2.4 million people, 400,000 of them receive Food Stamps. Our Medi-Cal program pays for nursing home services for 65 percent of the total revenues for the industry. More than half of the persons with mental disorders also have an alcohol and drug disorder, 2.7 million people.

The Health and Human Services area is partners with business that provide jobs, consumer protection, licensed healthcare facilities, licensed laboratories, and obviously license the professional individuals serving in those capacities.

The Medi-Cal program's cost per enrollee is the lowest in the nation. That's a very, very important fact.

TEAM LEADER SERTICH: Madam Chair, Commissioners, I'd like to talk a little bit about our team, just quickly. Chon mentioned that there were 275 members of CPR. There were 20 members of the Health and Human Services Team.

COMMISSION CO-CHAIRPERSON KOZBERG: Can you get closer to the mike, please?

TEAM LEADER SERTICH: Are we better? There we go.

Sorry.

Twenty members of the Health and Human Services Team, 16 current State employees and 4 former State employees. Among that, we had four former Deputy Directors of Health and Human Services Programs, one former Director of a Health and Human Services Department, and a former Undersecretary of the Health and Human Services Agency. We had quite a bit of power on this team to analyze things.

The total of the team had nearly 500 years of State experience. It was kind of mind boggling when we sat down and assessed who we had recruited for the team.

One key premise we looked at as we went through the review, and this is very important, in a January poll that the Public Policy Institute of California conducted there was a question that asked Californians, do they believe that government could be reduced, government spending be reduced and services be maintained for Californians? And nearly two-thirds, or over two-thirds, actually, responded favorably.

And you'll see, as we go through, that we kept that key thought and that the public may be very perceptive. And the perception is probably that we haven't updated our ways of doing business, we haven't taken advantage of technology, we haven't looked at some common sense applications that we could use in Health and Human Services.

We haven't been aggressive about federal funds, and other things like that.

So as we reviewed our issues and our programs, those were the things that we continued to keep in the forefront of our discussions.

TEAM LEADER PARKER: As Bob mentioned, and I think I can say this from personal experience in my role on both the Department of Finance and the Health and Human Services Agency, in the past, whenever there have been budget reductions, they've been made in the benefits and direct services areas to our clients and stakeholders in the Health and Human Services area.

We are particularly proud because our mission and our effort was to find ways to save over a billion dollars annually, basically without reducing services.

We looked at charting new territory. Some of these items are very bold, very creative, very controversial. But there's always been a focus to have a mission that combined these efforts and resources without reducing services.

At the same time we found that there was scattered responsibility for services and, obviously when that happens, there is confusion to the public.

So what we are going to present you today is 33 issues, 108 recommendations, amounting to $4.9 billion in

savings over five years.

To begin the issue recommendations, we've grouped them in a number of areas, and Bob and I will go back and forth to talk with you about them. These are a summary of them. Obviously, you've had the information and we will have great panel discussion today to elaborate on these recommendations.

But the first one that we want to talk about is the realignment issue. And it comes about by looking at the eligibility processing that we have for Medi-Cal, Food Stamps, and AFDC recipients. We believe it's costly and it's outdated.

The Health and Human Services programs have fragmented responsibility and need to be updated into the 21st Century.

We have a Child Support Program that under-performs.

So our recommendations are basically to go in and look at the use of technology to consolidate eligibility processing, save money, and basically to provide better services to the clients impacted.

We suggest the convening of a workgroup of state and county officials to help develop clear responsibilities for Health and Human Services programs. When realignment was done more than a decade ago, it was proposed by the

Governor at that point in time, but working groups were formed of county, legislative, special interest groups, and they produced the realignment that the counties in the State have worked under for the last, well over a decade.

We think that that kind of a group of interaction is absolutely essential to have these recommendations be effective.

We also think, particularly in the child support area, that competitive bidding for the operation of child support programs will enhance the ability for collections and also keep the cost benefit margins more within tolerable range.

TEAM LEADER SERTICH: Another area that we looked at were Children's Services, and we found a number of issues in Children's Services. We weren't able to exhaust everything, but we tried to look at the most important.

The findings we had were that child care in this state, State-funded child care is cumbersome and complicated. It's split between two State departments, the Department of Education and the Department of Social Services, and is operated by both, or authorized at the local level by both County Welfare Departments and the local Child Care Networks.

We also found that not all individuals that provide publicly-funded child care have criminal background

checks done on them. A concern when we're spending state and federal money on child care.

We also found what we believe to be that child care reimbursement rates are not linked to quality standards such as training and education.

In foster care we found a number of problems, and that basically the foster care system is in crisis and it needs new leadership.

And finally, we find that foster care children need permanent homes. The statistics on children who remain in foster care through age 18 are dismal. High arrest rates, high return to welfare, high homelessness after they leave foster care at 18.

And I think a comment here is that very, very few families in this State fully relinquish their responsibilities to their children at age 18 anymore, something that we need to continue to exam in the foster care and child welfare services area.

Some of the recommendations that we made are that we combine current child care into two phases, instead of the three. Basically, one for CalWORKS and one for all other subsidized low income child care.

Right now it's split into three phases, and the people who are caught in phase two are caught between welfare and low income subsidies, and caught on waiting

lists, simply because the system isn't seamless.

We also are proposing that we limit payments for providers -- or require background checks on all providers and limit payments, or eliminate them where background checks haven't been done.

We also are proposing to reduce reimbursement rates for providers who do not have formal education, or training, or licensure. Those are mostly relative providers. Not that they shouldn't be paid, but that they are not put at risk or have not gotten as much education and training as licensed child care providers.

In foster care we believe we need to create an assessment tool and publish annual reports about both state and county progress in foster care and outcomes. And particularly outcomes, not just process.

And then finally, to help adoptions and help get children out of foster care, we believe we should use celebrities for public service announcements, promote adoption, streamline the clearance requirements for adoptions so that more children have a chance to become part of a family and avoid the dire consequences that we see for children leaving foster care without being part of a family.

TEAM LEADER PARKER: In the areas of public health, mental health, and other services we found that technology is not being utilized in many of these programs.

Funding for public health programs is too burdensome and complex.

Protecting California's public health needs better coordination.

The State Administration of Mental Health and Substance Abuse programs do not maximize services well.

Vocational rehab. services do not perform well, compared with other states.

And HIV reporting is unnecessarily complex.

Our recommendations in this particular area are to use a State Electronic Benefit Transfer Network to deliver Women, Infant, and Children benefits. We found that this is absolutely the most paper-intensive program where we're still having paper of two and three dollar vouchers being processed by the Treasurer's Office, and at a time when technology should be handling these issues in a much more streamlined and efficient manner.

We've recommended the establishment of an online immunization register for children.

We're recommending the streamlining of administration of funding with local health departments for the distribution of public health services. We contract with them right now, but those contracts are usually for individual public health areas, overlapping and incredibly complex.

We propose that there should the creation of a State Public Health Officer.

We've also proposed to consolidate the State Departments administering mental health, and alcohol, and drug programs. As I noted earlier, in my introduction, over half of the people that are treated in either of these systems, both have dual diagnosis and we think it makes sense to try to have one portal to be serving them more effectively.

We're also suggesting to align the Rehabilitation Services with other State employment programs, to give broader opportunities to people that have gone through our Rehabilitation Services, to the work opportunities available to them.

And finally, to implement a names-based HIV reporting system so that we can take advantage of better coordination and also to maximize federal dollars, that if we don't move in this direction, may be lost to the State of California.

TEAM LEADER SERTICH: We looked at licensing and oversight programs in the Health and Human Service area, and we found a number of things. And this is the area where we mentioned we have a large network of business and professionals who help us provide health and human services in this state, and we don't have a common door.

But the findings that we have here are criminal background checks are inconsistent among the State programs in health and human services.

In child care, in some child care programs background checks are required, in others they're not.

In residential care facilities background checks are required.

And in health facilities, not all employees are required to have background checks. So there needs to be some consistency here.

We also believe that licensing and oversight for all HHS functions, or we see that they're scattered throughout the State, and we'll be talking about a recommendation there.

That is very difficult for business to do, to access one point for licensing services.

We found that licensing fee collections are very inefficient and State agencies do not do a good job documenting them.

And even worse, we found that licensure fee payers, those who are trying to provide health and human services in California, have been getting slow service.

And so we have a number of recommendations in this area. We want standardized criminal background checks among the programs. The Health and Human Service Agency already

has a task force working on that.

We want to guarantee fee payers receive services. We found, in some programs, after a fee is paid to get a license for a facility, it can be 8 to 12 months before that license is actually granted. And the business has to hire people, sign leases, and equip facilities.

We want to improve collections for Health Service licenses simply by automating the process, perhaps an internet-based system where people can go online to pay fees, that the programs will be able to track the fees accurately, and just improve and modernize that system.

We found that in managed care that streamlining of the oversight of managed healthcare plans is appropriate. There's four or five different ways that the State oversees health plans, depending on what category they fit in.

We're proposing that we streamline managed healthcare plans and consolidate the review process.

And then, finally, we are proposing to consolidate all Health and Human Service licensing functions. So that businesses, professionals, and consumers have one place to go to find out about licensed health and human services in California.

TEAM LEADER PARKER: One of the last program areas that we looked at is the State's healthcare program for families and Elderly. It's called Medi-Cal in California,

which is the State's Medicaid program.

Just as a little introduction, when we look at this from a budgeting standpoint, and how much we spend on these dollars, I said early on that we pay the least amount of money per beneficiary relative to any state in the nation.

But if you look at costs in Medi-Cal, it really revolves around eligibles, how many people you have on the program, the benefits that they are provided, and what you reimburse them.

Well, since we already pay the least amount per eligible as any state in the country, we tried to spend our time at CPR with looking at other ways that we could essentially meet the commitment, the goals objectives of the CPR staff to better utilize the scarce resources and dollars that we have in this area.

We found that federal funds are not always maximized. We found that technology improvements have not always or haven't been implemented. We found that competitive contracting can be used to save additional money. And we found that the current policies should be reviewed to ensure proper focus.

The recommendations tied to that are specific in several areas. And I apologize, I realize that many of you may not be used to all these acronyms that we have in the

Health and Human Services area, so I will explain a little bit about what all these names mean.

But the first one is to maximize federal funds by modifying the rates that are paid in what are called Intermediate Care Facilities for the Developmentally Disabled. We don't maximize the amount of federal funds that we think could be drawn down in this particular area, which in that sense would not change the service delivery to the client, but would help the State's fiscal situation.

We also propose to use technology for other insurance coverage tracking. We have found that there are, in many times, dual payments made for people who are both in the MediCare program and the State's Medi-Cal program.

We propose that there should be a competitive contracting process for the purchase of durable medical equipment for Medi-Cal recipients.

We also propose to reexamine what's called disproportional share hospital policies. These are funds that are received from the federal government that could be looked at, in totality, for our core Medi-Cal reimbursement for in-patient hospital services to our beneficiaries.

And last, but not least, we propose to transfer the In-Home Supportive Service Program to the Department of Health Services to maximize federal funds. Currently, most of this program, that provides homemaker chore services to

people who are living in their homes, but often are frail and in need of some sort of support to maintain their life in their home, we could draw down additional federal dollars, than having this be a program mostly supported by State and local funds.

TEAM LEADER SERTICH: After our team was finished looking at the program areas, we also focused on organization, as did all the other teams. And we like to call this Form Follows Function. That's what the title of the report, the section of the CPR report is, and we like to follow that.

We found that, in looking at the organization, that over the years departments and programs have become fragmented. Similar programs are in different State departments. Little pieces of programs have been developed when they really should be consolidated with other programs. We found that. Licensing's a good example.

We also found that administrative services were outdated and that new technologies, new approaches are available after the year 2000, that weren't available in the 1960's and '70's when these things were developed.

And that finally, the overall approach of the organization in the Health and Human Service Agency is much like it was in the 1970's, when the initial programs were developed. Programs have changed.

AFDC is now Welfare to Work. Food Stamps have changed. The Women, Infants, and Children Nutrition Program is on the scene. So we are looking at opportunities to change and consolidate.

What we propose is a Department of Health and Human Services that is focused around core functions, six main program functions and one financial center, because a lot of the business in Health and Human Services is financial.

We also proposed, among those consolidating, all licensing activities into one area.

We talked about consolidating all the health purchasing functions into one area. We have a Medi-Cal program, we have Healthy Families program, we have other health programs and they're operating largely independently. We believe consolidation would allow better leverage of purchase, but also would allow for the coordination of good activities and the replication of good activities among these programs.

We proposed a separate entity for Public Health, so that the positive public health message and the necessary warnings can get out to the people of California. Nearly every other state has a separate Public Health entity.

Currently, the public health functions are in the Department of Health Services, aligned with the Medi-Cal

program, which is large and overshadows that.

The proposal goes from 12 departments and one major board in the Health and Service Agency, and programs in five other State departments down to this new department, which has six Program Centers, and a Financial Service Center, and Administrative Services consolidated with a department head to serve all those centers.

Again, we made recommendations within our report on licensing, on the behavioral health, and the public health, and we believe this form follows function.

TEAM LEADER PARKER: In conclusion, we want to end our report with basically remembering Bob's point early on about the perception of Californians that we can reduce the cost to government, but maintain services to the beneficiaries.

So we believe that Californians are very perceptive, and we hope by what we have proposed here today that we can deliver on that perception.

We have $1.5 billion per year that can be reduced without affecting services. And I would essentially challenge that not only are we saying not affecting services, but we actually believe we will be improving services.

We believe that federal funding can be increased. And in areas we can also save dollars to the federal

government, which will put us in a situation of perhaps asking another level of government to be able to maintain those dollars, as opposed to having to go back with our hat in hand and asking for more.

We obviously believe government can use technology better, and there are many areas in our recommendations that simply, by doing technology, we can offer better services to the clients, and we can keep track of those, everything from necessary public health, to the citizens, to being able to track foster care children across the State, as they leave, so that they have the necessary information, moving from one part of the state to another, on health records, education records, et cetera.

But as we said, we believe overall that coordination of services can be improved. Bob and I sit, representing our team of 20. We feel we have given the Commission and basically, the public in general, some good food for thought.

We are available to answer any and all of your questions and look forward to being able to debate these policy issues. Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you for that excellent overview, and please thank your colleagues for all their hard work.

Questions from the Commission? And if I cannot

see you, can you make sure you badger me. David Davenport.

COMMISSIONER DAVENPORT: Yes, as to this last point about coordination of services, as you read through the report and the various recommendations, you see both the lack of coordination at the State level, and you suggest several consolidations that may help with that.

But you also see so many other players and so much other money, federal money, obviously, and players at the table, state money and players, county money and players, perhaps other local entities. You even have some recommendations about increased privatization.

So you begin to think well, really, somebody needs to coordinate that as well. Is the State presently playing that role, in your opinion, trying to sort of coordinate or broker among federal, state, local, private entities?

Do you read your own recommendations as increasing the role of the State in that sort of coordinating way?

Would that sort of coordination be welcome, do you think, from the State at other levels, county, federal, and so forth, or would there be resistance?

And are your recommendations strong enough to increase coordination among all those various levels? And I'm speaking now not the coordination within the State, itself, but coordination among these other major players.

TEAM LEADER PARKER: I feel like that's a Ph.D.

dissertation. I think Bob and I both probably have some thoughts about your questions, perhaps, both given our, as we said, very long experience in State government.

The first thing I'd like to do is answer your question by limiting it to Health and Human Services programs. It's very, very difficult to talk about the State in totality, and the complexity of overlap of all of these issues. We see it even in the complexity of overlapping with sister state agencies.

My new role now, in running the Housing Finance Agency, many of our clients and the people who we serve in our programs are clients and recipients in the health and welfare area. So there is incredible overlap.

But I think I would say, in my years of government, that you cannot do Health and Human Services programs without looking at these as partnerships. We have partnerships with the federal government, we have partnerships with local government, and we have partnerships with many nonprofit and advocacy groups. They are either a funder or deliverer of these services, and we have to essentially recognize that we are partners, not necessarily dictators in what can and should be accomplished.

So I would think that, and we'll have a panel, certainly today, to talk about the relationship with state and local governments, that many of them would welcome a

discussion along these lines, better coordination and efficiencies. Because, frankly, the State doesn't have a lot to commend itself and pat itself on the back. We are just as guilty as everyone else is about lack of good coordination of services.

So at least initially, and that's certainly what we're waiting to hear today, we think that people are open to better coordination because the system doesn't serve, well, people today.

TEAM LEADER SERTICH: Additionally, the structure that CPR is proposing for Health and Human Services, and other areas of State government is aimed at better coordination.

The super-department of Health and Human Services, a huge task to coordinate all the federal funding streams and all the relationships with local agencies, but that is the place where it should start to flow better, if they're coordinated.

And actions that we took, you asked. The In-Home Supportive Services Program is largely funded by federal Medicaid dollars, but it's not in the department that manages the federal Medicaid dollars. We are proposing it be moved there.

The Department of Rehabilitation's employment programs are largely linked to other federal employment and

state employment dollars. We are proposing that they be moved there.

So there's some recommendations that improve coordination, but it's something that State government and Health and Human Services overall has to focus on.

CO-DIRECTOR GUTIERREZ: Commissioner Davenport, just a minor point. In the broader context you'll be looking at the proposal that we've made to reorganize State government. And the point you made weighed heavy on our minds. And we are going to be recommending to you, and to the Governor, the concept of Coordinating Councils, and you'll see it at different levels.

In the education area, particularly with vocational education being such an important element, and having different constitutional organizations addressing both those subjects, we think there's value in bringing them together to talk about long-term strategic policy.

And maybe they're independent bodies, but if they meet periodically and have discussions on common themes, perhaps that will allow for better coordination and better management.

It is an issue that we did look at and we have a couple of indirect ways of dealing with it, but we have no direct recommendation on that point.

COMMISSION CO-CHAIRPERSON KOZBERG: I have the

following Commissioners that wish to ask questions, and we'll take you in this order; Jim Canales, Joel Fox, Peter Taylor, Steven Olsen, J.J. Jelincic, and Russ Gould. Okay, thank you.

The next question is Jim Canales.

COMMISSIONER CANALES: Great, thank you, Commissioner Kozberg.

I wanted to come back to the first section around transforming eligibility processing, because of the 300 or so pages in the report related to today, this took up about seven pages, and it actually captures about $4 billion of the $5 billion in savings that you have identified for this entire section.

So I'd love to have a little bit more sense of some of the nuance that's in that one section that only covers seven pages.

And I guess, in particular, I want to come back to one of the assumptions that you articulated on several occasions throughout the presentation, having to do with wanting to contain costs without reducing services to the people of California.

Given that, talk a little bit about how you see the process that you've described here, in terms of transforming eligibility processing and moving to a more technologically-oriented process as a way that is obviously

going to lead to some cost savings, but at the same time, and this is the part I want to focus on, at the same time not reduce services to the people of California, particularly those who may not have access to technology, as well as those who may be better served by having an individual work with them through these kinds of complicated processes.

TEAM LEADER PARKER: Okay, Bob and I will tag team this one. And thank you for asking about this one because, clearly, we see it as sort of the cornerstone of the report because of the dollars that we believe are freed up and the opportunity, in that sense, to use those dollars for other dramatic reform in Health and Human Services programs.

I think it's interesting, we were trying to be good soldiers about reducing the narrative on these proposals. Obviously, given the complexity of them, we could have written small tomes on each of them.

But the eligibility one is, I think, a good one for us to discuss. You know, we essentially said this process started in the sixties. That was at a point in time before faxes, before the technology that we have today, and we used the counties essentially as a direct point of contact to determine eligibility for these, you know, we're-on-poverty type programs.

The reality is that today, in 2004, we're sort of

still doing the same thing, where we were a much smaller state. And we talk about globally and, yet, we still have individual county welfare departments. And it isn't always necessarily just about access.

We came upon this particular issue, as worked on by one of the experts on our team, and it's come about for two reasons. One of them is that the Healthy Families Program, that Bob mentioned, uses technology in its eligibility determination, and let me just be clear that we're only talking about the front end of the eligibility process. Just the processing part, just the paper part.

We're not talking about what happens to the client that may be going through an eligibility determination for Welfare to Work, and once the paperwork is done the person then works with a social worker on their assignments, et cetera, et cetera. We're just looking at the paperwork.

The Health Family Program serves similar client groups. It costs $77 to do an eligibility determination in that program.

Now, I will be the first one to say that clearly these programs are more difficult. But we have taken that into consideration in the amount of dollars that we have assigned to the cost.

But we have also proposed that there be a way for people to have direct personal contact, in addition to 24-

hour access on the phones, that's not currently to anybody applying through Welfare.

They can apply 24 hours a day. We see that this may not be just their own technology at home, it could be through nonprofits that they have access through, that are providers or services at hospitals, at places that are open seven days a week, 24-hour days.

That's a big improvement to what the eligible person has right now, with often being limited to a welfare office that's open between 8:00 and 5:00, Monday through Friday. They often have to leave their jobs, take their children out of school to go down. So we see this as being an improvement.

And our average dollar amount from this system, based on what we're currently doing in Health Families, is $111 versus the approximately $350 for eligibility determination that is occurring now.

COMMISSION CO-CHAIRPERSON KOZBERG: Commissioner Joel Fox.

COMMISSIONER FOX: Thank you. Could you just touch on, please, your approaches to keeping the private healthcare providers within the Medi-Cal system, that are fleeing the system, the concerns they've expressed, the expeditious payouts, things like that?

TEAM LEADER PARKER: Well, I think that goes back

to my earlier comment about what the reimbursement rates are for providers. And I think what we've tried to focus -- two things, to answer your question directly.

One of them is we're proposing the consolidation of health purchasing, and by doing that to see if there is a more efficient and effective way that we can leverage these huge state dollars that are spent in the healthcare delivery system, which may include a more rational reimbursement system than we currently have.

And by also being able to free up dollars, then in tough budget times, where we often have to go to these programs to cut them back in order to save dollars, by saving and using these efficiencies, it may leave dollars in the systems that otherwise would have been cut in order to maintain the service delivery system or the providers that we currently have.

COMMISSION CO-CHAIRPERSON KOZBERG: Peter Taylor, then Steven Olsen.

COMMISSIONER TAYLOR: Thank you, Madam Chair.

In the new, proposed org. chart for the Health Services Agency, you talk about consolidating the purchasing function under Secretary for Health Purchasing Division, but in one of the many books we received, Prescription for Change, where you talk about how the State can do a better job managing pharmaceutical costs, and that it's not now

currently leveraging its considerable buying power through Medi-Cal and other sources, you talk about consolidating the purchasing function in the Department of General Services instead of into this new Purchasing Division. Why not put that function with the Health and Human Services where, presumably, some matter of expertise lies?

TEAM LEADER SERTICH: Everything, I guess, wasn't perfectly coordinated. Major purchasing for other State departments rests with the Department of General Services.

We also contributed to a recommendation in that portion, in the procurement portion of the report that says that by rearranging the way we deliver health services in other State departments, for example, Corrections or Mental Health, we could take advantage of significantly reduced federal prices available, public health prices, essentially, for things like what the Veteran's Administration gets, by organizing it.

And that was one of the recommendations in that section that we contributed to.

It also talks about having a Council, that includes people from the health purchasing area to help direct those kinds of purchases.

That's the best answer I can give you on that. But we did contribute to that part. It may not have come through on the report.

CO-DIRECTOR GUTIERREZ: Let me just say that your focus is right on the money. The document that you have in front of you reflects the fact that we'd already moved forward with a strategic purchasing contract through the Department of General Services, which is already reaping benefits.

To the extent that we consolidate and leverage our ability to purchase, that's the basic policy that we were pursuing.

And so if there's a way to put the pharmaceuticals for all the other entities in government, beyond Health and Human Services, we're absolutely for that.

Thank you for raising that issue.

COMMISSION CO-CHAIRPERSON KOZBERG: Steve Olsen.

COMMISSIONER OLSEN: Terri, Bob, thanks for your outstanding report and congratulations to you and your team.

I have a question about the Program Realignment Recommendation, your second recommendation, and there may be other recommendations that make changes in the state/county relationship.

I recall that the 1991 realignment was successful because the transfer of mental health and public health programs to the counties was accompanied by a subvention of sales tax and realignment of VLF revenues.

This one is different in that there is no revenue

component to it, it involves a transfer of programs, Mental Health, IHSS, Child Welfare Services, and the Medical Indigent Services, some to the State, some to the counties.

And my question is whether or not either of the ballot measures that are on November, either Proposition 1A or Proposition 65 would make any changes in the mandate provisions of the Constitution that would make it difficult or impossible to affect transfers of financial responsibility to the counties that are not actually accompanied by a subvention of State monies, rather than a swap of programmatic responsibilities.

Is that what the Legislature and the sponsors intended, that realignments of this sort would be prohibited or at least would require voter approval in the future.

TEAM LEADER PARKER: Okay, let me see if I can answer your question.

First of all, just to put a little context together on this. We proposed this and we called it realignment, because we were very successful in the proposal in the early 1990's.

And we thought, with the first recommendation on changing the eligibility determination, and the freeing up of significant State dollars, federal dollars and, I might add, $200 million to the counties, that that could be used as a basis for negotiations for our realignment component.

Now, I know if you read the issue, it talks about perhaps bringing Medically Indigent Health Services to the State, to form a larger purchasing pool.

It talks about maybe giving counties more direct responsibility in Child Welfare Services.

We will say, Bob and I, that we did not feel that we had the magic answer, in the amount of time that we had, to say what, specifically, realignment should be.

More, what we would suggest to our colleagues and the public, in general, is that we think the eligibility provides an opportunity for those kinds of discussions and people to work at what would be the best alignment of services to be paid for and run by the State, and what would be more efficient and effective at the local level.

To answer your question, Steve, directly, I have had some conversations with the county folks that are involved in those initiatives. I don't think that they create an environment that this could not occur.

I think the positive thing about it is if those were to pass, the counties would have more assurance that in the future, if they were to take on some of these programs, and they raised funds accordingly for them, those funds could not be later, how can I use this affectionately, ripped off by the State, and then in that sense used for the programs that they asked the voters in their communities to

pay for.

It is certainly, my last comment, the reason why we are going to go down this path, we need the expertise of a great many people, in a room, to figure out all of the complexities, huge legal complexities when we did this. The complexity's even greater now.

COMMISSIONER OLSEN: Okay, thanks.

COMMISSION CO-CHAIRPERSON KOZBERG: J.J. Jelincic and then Russ Gould.

COMMISSIONER JELINCIC: There's a bias throughout this that deals with privatization being more effective, more efficient. I'm not going to get into that one. But as a State employee, I agree that sometimes it makes sense to contract out. Frequently, it doesn't.

But you recognize the diversity of California and the fact that, you know, the counties have different economies, they have different social cultures, they have different languages, and yet you're proposing to consolidate, at a State level, a number of these very local services.

And I was wondering if you can explain to me why you're doing that, and does that limit our ability to construct local services, with local control, to meet local needs?

TEAM LEADER SERTICH: Commissioner, if you're

talking about the eligibility thing, which is the main one, we believe that it provides more opportunity, more flexibility.

Statewide internet access, statewide call centers provide volumes that would allow us to respond in many languages. That's one issue.

The second part of the proposal is we would propose to pay community-based organizations, and local medical clinics, and other health providers fees to help people get eligible through the process.

So we think those two factors actually provide us more flexibility and more, perhaps, diversity of opportunities than the current system where we have permanent government employees trying to shift, daily, in serving people's needs. So we believe we've built flexibility in.

Do we need to still discuss that? Probably, we do.

COMMISSIONER JELINCIC: The In-Home Supportive Services, in particular, your proposal is to consolidate that at the State level and to contract it back to the counties, and I'm not sure I understood the point of doing that. But doesn't that, in many ways, weaken the reforms that we put in, in '99, to deal with the program?

TEAM LEADER SERTICH: Our proposal just talks

about shifting the State management of the program from the Department of Social Services to the Health Purchasing Cluster.

We anticipate that counties or local folks would still determine the level of service, given the federal guidelines, as they would now. So we're not, there may be a little misunderstanding on that.

That consolidation was driven to maximize federal funding, that's the driver on that issue.

COMMISSION CO-CHAIRPERSON KOZBERG: Russ Gould.

COMMISSIONER GOULD: Thank you. First, to Terri and Bob, I really appreciate the quality of the work that you've presented today. I had the good fortune of working with you during my State career and, certainly, the work you've done is exceptional. So congratulations to your team.

You know, we've touched on a couple of questions on the idea of realignment and, clearly, there has been some success. There's also been some failures in terms of trying to promote additional changes in the structure of state and local government.

It's clearly one of the big ideas in your report. And even though you, I think appropriately, indicate that it ought to go to a working group for really sorting through what the right determination is, I wonder if you could just

spend a couple of minutes talking about your thinking about the kind of restructuring, by program, and between state and local government, because I think it's important just to put a framework around it.

So if you could, just spend a couple minutes going through that?

TEAM LEADER PARKER: Okay, I'll try to see if I can meet your expectation.

One thing I'd like to point out, and again I'd point to the panel that I think you have to talk about this issue in a few minutes. Many of the people who are actually in the day-to-day responsibility of being service providers, the local health officers, local county welfare directors are going to be here to give you their insights.

But I think it's kind of important to say that we've tried to look at this as how these programs have evolved over a number of years. And that's really difficult in Health and Welfare because we're always in the process of trying to look at how to make them better, and we spend a lot of time trying to look at how to make them better. And meanwhile, these programs change and evolve on their own.

And so sometimes they're evolving and changing and we're still looking at something that was the way the program worked a year or two ago, so the challenge is particularly great in this area.

Bob's given the example of In-Home Supportive Services is one. This is a program that primarily had been funded by State General Fund, and county funds, since its inception, and the eligibility determination and services provided by counties, some of them through county registers, some through individual providers.

But we have found that many of the services that they provide are really of a health nature and therefore, by consolidating this into more of a health program, we can draw down federal dollars. Which again, it will continue to provide those services, not changing the services, but also not impacting the State General Fund as great, and in that sense, in tough fiscal times, will allow us to continue.

But to sort of answer the question directly, the State has several health programs, whether it be Healthy Families, or Medi-Cal. We set rates through a Hospital Rate Setting Commission. We set rates in the Department of Health Services. We set rates in the MRMIB programs.

We don't benefit from having one entity now set rates for Medi-Cal programs in totality, we also don't have the benefit, then, of looking at how we could leverage providers of those services with reimbursement rates or access that could best provide our clients.

So part of our proposals are to put these together to see whether or not we can take the best of some of these

programs, Healthy Families, how they do it, not to make that program worse, but to take some of the best qualities of that and to mix into some of our other programs.

The Little Hoover Commission, that's going to speak today, is going to talk about their own ideas of how they looked at consolidating Health and Human Services Programs and the relationship with local government.

Their ideas were very much on the concept of using the State as the sort of super-coordinator, the person to relate to the federal government, to do best practices, where the local government really is the hands-on delivery system.

We don't say that that's a bad idea. I think what we've essentially said is there's many different ways you can do this. What's really not acceptable, though, is the current system, it really needs to change.

So we've talked about health purchasing, and bringing health programs maybe to the State, so you have leveraging.

We've made the idea about child programs going to the locals because, again, the counties are the direct people in the community that provide these services. County welfare programs are often for families who are in distress. They may be people who are in the welfare system. They may be in the local mental health system. Their children may or

may not be part of the Juvenile Justice System. They're certainly, if they're age appropriate, in the education system.

And so we've essentially said maybe, given that the counties are in a better position, if they have the dollars, to make appropriate decisions in their communities about services to those groups, rather than coming from the State level, that all sizes are the same, all counties are the same.

And so some of it is trying to be recognizing that State is more of a purchaser, the counties, in healthcare delivery, have become more of a purchaser as opposed to a direct provider of service, and restructure to better recognize what's happening today.

We will outgrow what we have proposed, just as we have sort of outgrown what we did 10, 12 years ago, but it's kind of a continuum.

Russ, I hope that provides some perspective.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. We are running out of time, but I have the following people that wish to ask questions. And Terri and Bob, if you could shorten your answers, though we certainly appreciate them. Jay Benton, Leland Yee, Pat Bates, and Denise Ducheny also had a question.

Okay, Jay Benton, then Leland Yee.

COMMISSIONER BENTON: Oh, thank you. I have just one specific question. We've been dealing this morning, appropriately, with the broad issues of your recommendations, but one struck me as uninformed in this area, as well as others, and that was dealing with the $50 child support item. I realize that's specific, but it caught my eye because it's the only one that has a number in it. I mean, it's very specific.

Could you just take a second and explain, as briefly as you can, what that's about?

TEAM LEADER SERTICH: In the nineties, in the early nineties, or prior to that I think, federal government allowed states to pass the first $50 of child support collected on behalf of a child, who was in the welfare system, on to the family without reducing the welfare grant.

That was changed in the late nineties and it became a hundred percent state cost, so the federal government didn't participate.

We looked at things that California was doing, that other states weren't doing, to see if they made sense.

We looked at reports, and there's several reports out. The idea of passing that on is it would continue to provide an incentive for the absent parent to pay that money because the government wasn't taking it.

Studies of what federal government's done in other

states, indicates that the incentive, that they can't prove any link between the incentive. And we're saying it's a hundred percent state money, let's just reduce it.

COMMISSIONER BENTON: Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Assemblyman Yee.

COMMISSIONER YEE: Thank you very much. I really appreciate the hard work that all of you have put into this particular document.

Let me start off by saying that I support the work that you all are trying to do, which is to really try and look at efficiencies, and cost savings, and so on.

Ms. Bates and I, and Senator Ducheny and I, we're struggling in the Capitol to figure out how we're going to close a budget and not do grave harm to the people of California.

However, there are things in here that I want to just kind of share with you in terms of at least my reaction, and see how you want to respond to it, and it has to do with the issue that you've identified and that is the realignment issue.

You know, in my past life I was a psychologist, I worked in a mental health program, and realignment was not necessarily a great concept for all of us who were at the front line of providing services.

Realignment, and I guess Mr. Olsen sort of outed himself in terms of his age, and I have to say that I went through that same experience with him, so we're both pretty two old guys.

But in realignment what happened was that the state shifted responsibility of providing those services to the local government, and the selling point was that was great, it was local control, and so on. And there was a revenue, dedicated revenue stream for that, and so everybody was pretty happy.

Then over the years that revenue stream started to decrease, however, the responsibility was still there. And oftentimes what happened was that local government was put in the unenviable position of then starting to change criteria so that some people got services and other people did not get services. And lo and behold, you started to have people living out in the streets, and so on.

So it's rather interesting now, in your proposal, you're looking at another form of realignment, which is to kind of then take some of that responsibility away from the local government, and then put it back up to the State, and particularly with the IHS workers and the medically indigent adult.

And I think the concern that some people may have is that is this another way of maybe then taking some of

that responsibility away from the local government, and so at the State level you'll somehow decrease eligibility and then decrease the number of individuals you serve.

But ultimately what you end up with are individuals who are not going to get the services and not going to get the help, and then all of us in local government then suffer because we've got to somehow figure out how we're going to deal with those individuals, because they're out in our streets, they're down on our corners.

So do you have any comments about how we can allay that concern and how we can still provide services for these individuals that you've identified?

TEAM LEADER PARKER: I think your point is excellent and, actually, it's right on point.

The issue of trust between the State and local is an ongoing issue. And really, to the best of the benefits of the services that we provide the people, the State has to have a trusting and the county has to have a trusting relationship.

I would say I am fully aware of what happened in the mental health example you've given. I think the only thing to say about it is that had it not been transferred to the local government, that given the State budget crisis we were in over the next several years following that, there probably would have been no dollars for mental health at

all. So at least there was some left at the local level.

I answered Mr. Olsen's question earlier on. Some of what we've proposed in here is a high risk behavior for the State. The State has traded the Medically Indigent Program between the local government and the State government, and its funding, many times over its history.

Fundamentally, the counties have a responsibility, under Section 17000, to be the provider of last resort for health.

If there would be such a transfer proposed in this realignment structure, the issue of 17000 I'm sure would be on the county's minds because they could not longer be held accountable as a provider of last resort if, in fact, they traded that responsibility off to the State for services perhaps to children. So that's one part of the answer.

The other part of the answer is, again, if the initiatives from the ballot passed, that no longer allowed dollars to be shifted, if there was insufficient funds at the local level for provision of some of these services for children, in this particular example, the locals would be in a position of having to decide if they wanted to raise revenue, much as the State would be, in order to raise revenues to provide services.

But if the community made that decision, at least they would know that those dollars were going to be going

for the services that they, in their communities, voted on.

So we think that while, again, it's not a perfect system, it does recognize and build on what was done ten years ago.

COMMISSION CO-CHAIRPERSON KOZBERG: Assemblywoman Bates. And Senator Ducheny, but I think she may have stepped off the podium for a moment.

COMMISSIONER BATES: Thank you. In the interest of time, I'll just actually make a comment and hope I hear from you, the answer.

Having been a line worker, actually a county welfare worker for many years, they always bypass those of us on the line for suggestions. I did not notice in the footnotes that there were a lot of actual eligibility or social workers providing commentary.

They become the reality check on whether services are really being delivered when you change program approach and bring in new systems. They're also the reality check for whether there's cost savings.

I know that with the Healthy Families, Outreach, and the Application Assistant Program that went in, a lot of mistakes occurred, honest mistakes, people becoming eligible for those programs, who in fact weren't, and were discovered 60, 90 days later, and even longer, not being eligible.

So it's my hope, as you go forward in this reform

process, that those folks that are actually out there doing it will become a key element of this working group that you put together, that can address both the realignment issues and the delivery of services.

And I applaud you. We spent many, many hours two years ago, in the budget battles, wanting to ensure that the dollar that is spent by a taxpayer is really going for services to those people who most need it, and not to growing a bureaucracy that's supposed to be there to administer or to validate, and you have really struck at the heart of that.

But don't forget the key equation, the relationship between the service provider and the person needing service is critical to ensure this works.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you very much. Thank you for an excellent overview.

We're now going to move to our first panel, and those are the -- it's the Services Delivery Panel. And if you could please come forward.

And while you are setting up, if we could just go around, I understand several of you in the audience want to know who we are, and if we could just briefly introduce ourselves to you. Starting with Assemblyman Yee.

COMMISSIONER YEE: My name is Leland Yee, I'm Speaker Pro Tem of the California State Assembly.

COMMISSIONER TAYLOR: My name is Peter Taylor, I'm a Managing Director at Lehman Brothers, in investment banking.

COMMISSIONER O'NEILL: I'm Beverly O'Neill, the Mayor of the City of Long Beach.

COMMISSIONER OLSEN: I'm Steven Olsen, I'm Vice Chancellor for Finance and Budget at UCLA.

COMMISSIONER BENTON: I'm Jay Benton, Retiring Chief Operating Officer, currently Executive Vice President, ABM Industries.

COMMISSIONER CANALES: And I'm Jim Canales, President and CEO of the James Irvine Foundation.

COMMISSIONER BATES: I'm Assemblywoman Pat Bates, I represent South Orange County and North San Diego County, Assembly District 73.

COMMISSION CO-CHAIRPERSON KOZBERG: I'm Joanne Kozberg, I'm a Partner in California Strategies.

COMMISSIONER GOULD: I'm Russ Gould, I'm the President of the Gould Group, and former Director of Finance and Health and Welfare Secretary for the State of California.

COMMISSIONER DANDO: I'm Pat Dando, I'm Vice Mayor for the City of San Jose.

COMMISSIONER FRATES: I'm Steve Frates, a Senior Fellow at the Rose Institute of State and Local Government.

COMMISSIONER FOX: My name is Joel Fox, I'm with the Small Business Action Committee.

COMMISSIONER CARONA: I'm Mike Carona, I'm the Sheriff of Orange County.

COMMISSIONER BONNER: I'm Dale Bonner, the former Corporations Commissioner and now a private attorney in Los Angeles.

COMMISSIONER JELINCIC: I'm J.J. Jelincic, President of the California State Employees Association. Since I represent workers, I'm the only special interest on the panel.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. And now we have our panelists. And if I could ask you to do self-introductions, please, and then the first panelist we're going to hear from is Jim Mayer.

Sam, do you want to just briefly, just go through the Panel and introduce yourselves.

PANEL MEMBER KARP: Sam Karp, from the California HealthCare Foundation.

PANEL MEMBER MAYER: Jim Mayer, with the Little Hoover Commission.

PANEL MEMBER LIGHTBOURNE: Will Lightbourne, with the County Welfare Directors Association.

PANEL MEMBER MAULHARDT: Steve Maulhardt, with Aegis Medical Systems, representing CAADP.

PANEL MEMBER SOUZA: Dan Souza, representing the California Mental Health Directors Association.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. Oh, sorry.

PANEL MEMBER KONDYLIS: Barbara Kondylis, Solano County Supervisor, representing the California State Association of Counties.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

PANEL MEMBER HORTON: Dr. Mark Horton, I am County Health Officer for Orange County, and Deputy Agency Director for Public Health Services.

COMMISSION CO-CHAIRPERSON KOZBERG: Great. Can we just have you move in just a little tighter, it's a little difficult to see you there.

And again, the first person who will testify is Jim Mayer, from the Little Hoover Commission.

And then we'll hear from Mark, Sam, Barbara, Will, Stephen, and Dan.

And if you could introduce yourself, first and last name, because the audience behind you will have difficulty in understanding who is speaking.

Jim.

PANEL MEMBER MAYER: Good morning, Madam Chairman, and Commissioners. My name is Jim Mayer, I'm the Executive Director of the Little Hoover Commission.

The Commission, certainly, greatly appreciates the opportunity of the California Performance Review, and in the process here we've shared as much as we can of previous work from the Commission, including a whole set of recommendations the Commission's made over the last decade that deals in the area of health and human services.

And some of them dealt rather specifically. We've done work in the area of foster care, and child care, and child support enforcement. We've done work in the area of drug and alcohol abuse, mental health, mental health for children. We've looked at the Juvenile Justice System and the intersection with the Health and Human Services system. We've looked at the Parole System and the relationship with the Health and Human Services System.

About two years ago the Commission recognized how greatly important it was to truly coordinate and improve the performance of these systems and, through that, initiated a project to look at how to go about redesigning the Health and Human Services at the State level, and the service delivery throughout California.

What I wanted to do this morning was draw on some of those recommendations to share with you some of the conclusions the Commission's reached. Some of those are similar, or identical to recommendations that are in the CPR, and where those are there, I'll try to point those out

for you.

I want to make clear, the Commission, itself, has not yet reviewed the California Performance Review, although it anticipates that those recommendations that would take the shape of the Governor's Reorganization Proposal would come to the Commission.

So what I'm offering you today is really testimony that reflects what the Commission, how it has reviewed these issues and, hopefully, that will allow you to think about some of the recommendations that have come forth from the Performance Review.

There's a couple of important groundwork things that I think has guided this bipartisan independent Commission's view of this. And the first is that these are very important issues to be dealing with. Not just if you're interested in government, or you love government, or you're trying to help people who are poor, or have disabilities of one kind or another, that in fact there's a growing amount of evidence that documents the impact on public and private enterprise if we do not provide adequate mental health care, if we do not provide adequate drug abuse treatment.

I mean, this is billions of dollars for the State of California, impacted as much on private sector as public sector.

And so the outcomes from the system, that we deal with in government, very much impacts the ability of the State of California at large to reach its public, and private, and personal goals.

The second is, is that the actual performance here matters on the State budget, itself. There's a variety of ways of looking at this. Earlier, we saw the slide that said $64 billion are spent within this arena. And clearly, the challenge here is can we spend those $64 billion in this year, and next year, and the year after that to have a better outcome, to improve the performance?

But it's also critical to recognize that how successful we are with these programs will drive future budgets. In fact, many of the costs that, when you sit down to understand the budget or to make budget decisions, as Mr. Yee has said, are being driven by the success or failure of the programs we're talking about today.

The Columbia School estimates that the State of California, a couple years back, was spending $11 billion out of its General Fund dealing with drug and alcohol abuse. That's not $11 billion in the Health and Human Services Agency, that's $11 billion on problems that occurred, the criminal justice problems, the healthcare problems, the public safety problems.

So you can see that if we could reduce the drug

and alcohol abuse problem by 10 percent, we can substantially impact public cost.

The third and final item there is that we're not doing a very good job and we share, I think, in frustration that while we've been at this for, now, 30 and 40 years in some of these program areas, that we're not dramatically making the progress.

And my written testimony identifies some very specific elements of how you might want to measure that, whether it's crime or foster care.

The good news is that when you look around the State of California and the nation, there are islands of success. In fact, we know we can do better because we are doing better at particular service providers and certain communities, and we know that we're doing better.

There are cases where we do the double somersaults and stick our landings. But the problem is that those become isolated cases, that's not what's driving the system.

And so the challenge is how do we get the system to move towards optimality, to move towards the most effective things.

When you look at that, you find that the system is not designed to do that. In fact, it's designed, it's fractured, as the CPR analysis shows. The funding oftentimes has driven how departments are aligned. It's

fractured at the State level, it's fractured between the State and county. It's fractured at the regional level, where some of these issues are done.

And by fractured, we don't just mean that there's programs over here that are duplicative of that. We mean that it's difficult to ascertain who's really responsible for what. And even when you sit down in detail and talk about a specific program, you get disputes among the professionals about where their responsibilities begin and end.

It is impossible to improve the performance to the system, until it becomes very clear how every individual impacts the outcome of a system.

So what has the Commission said? In the report that I've provided you a summary, it provided a broad outline, as well as some specific process and some specific recommendations about how the State could go about rethinking this.

And the first is that very clearly, where we've identified dramatic system change, and there's been agreement among budgetmakers, policymakers, program administrators, the implementers that Commissioner Bates was talking about, about what we're trying to accomplish, how we're going to measure our performance along those lines.

They have to drive budget decisions, they have to

drive policy decisions, they have to drive program and management decisions.

It isn't just that we agree today that the purpose of this bill is to X, and then tomorrow we're going to do another bill that isn't compatible with those goals.

The performance budgeting recommendations of this Panel's work, of the CPR's work, speaks to that. And so outside of the specific area there's some important recommendations to consider.

The second is clearly the State needs to get its house in order. Our idea about how the State should go about redesigning its thing, thank you very much, is that it should be based on that right service at the right time, to the right individuals. And that the recommendations we gave you were based on the State agencies that would do that.

Just one quick, final note. The Commission clearly observed that more than how the State organized its functions in the area of health and human services, because so many of these services are delivered in the community, because counties have such a large role, that the vertical relationship here, the state/local relationship, and what that actually looks like is as important or more important to what happens at the State level.

And the most important thing we can do at the State level isn't to figure out how to do it at ten percent

less cost, it's how to do what we do at the State to drive performance at the local level.

Of the $64 billion, less than a billion is spent in Sacramento. Thank you very much.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. As we go forward with the Panel, we're asking you to focus on those issues that you do have agreement with the report, and where you do not have agreement, and where you may have an alternative suggestion that you wish to put forward.

Mark.

PANEL MEMBER HORTON: My name is Dr. Mark Horton, I'm the Health Officer for Orange County, and I'm very pleased to be here and think it's an honor for me to be here to present some thoughts to the Commission.

I want to compliment the CPR process, in general. I think a huge amount of work has been done and some very cogent recommendations have been put forward.

I also, specifically want to compliment the staff in putting that huge document in a web-based format that was very, very user friendly. I thought that was good.

And I also want to compliment the Governor on the scope and depth of the Commissioners. Particularly appreciate Assemblywoman Bates and Sheriff Carona being on the Commission.

I represent the California Conference of Local

Health Officers. This is an organization of 58 physician health officers representing each county, and three health officers representing three municipalities.

By statute, we provide advice to the Department of Health Services and to the Governor on key health issues.

I have some overarching issues that I'd like to talk about. First, I want to compliment the CPR process in honing in on performance in government, the establishment of performance standards and measures in each program, and working toward performance-based budgeting is absolutely the right way to go.

We do think it's the wrong way to go to put that responsibility in the Department of Finance. We think that keeping planning and performance accountability separate from financing is key. What we do and what standards we should hold those to, those should be separate questions from what should we spend our money on and how much we should spend it on.

We are also concerned, in general we think there was good work done in the boards and commissions area. What I did not see reflected in the CPR document was clear criteria on why certain boards were kept and why certain boards were not kept. Do not throw out the baby with the bath water. Be clear that there are certain governmental functions that require important input from the public and

from key stakeholders.

We support the idea of removing key federally funded programs from State hiring processes, travel restrictions, purchasing, and other restrictions. We have seen severe restrictions on our ability to become ready, as a State, for bioterrorism, and other terrorism things as a result of these restrictions in fully funded federal programs. We need to change that.

We also agree very much with simplifying contracting processes between the states and local jurisdictions. Local jurisdictions are only now finalizing our arrangements with the states on the reception of our bioterrorism funds for '03-'04, six weeks beyond the end of that fiscal period. This is unacceptable. We can do better.

On specific public health issues we very much support the establishment of a separate Department of Public Health within the Health and Human Services Agency. This is consistent with the Little Hoover Commission report and consolidates, but not all, core public health programs under administrative leadership, reporting directly to the Health and Human Services Secretary.

We support the establishment of a State Public Health Officer, a Physician's Health Officer, who has administrative responsibility for core public health

programs, but should advise Department of Health Services in general, and the Governor, on all key health issues.

On specific programs, we support the move of the California Children's Services Program into the Purchasing Center within Department of Health Services.

We also support the retention of the OSHPD, the Office of State Health Planning, in public health. We think the Commission ought to strongly consider elevating the responsibility of that entity, resourcing it properly to provide broad support in Health and Human Services for planning, for performance accountability within that Agency.

We oppose moving the Supplemental Food Program for Women, Infants and Children, or the WIC Program, to the Social Services Agency. We think this program, in addition to being a food distribution program, had essential public health functions that should be closely aligned with public health.

We also, in the environmental health area, support moving OEHHA, the Office of Environmental Health Hazard Assessment, into the Department of Public Health. This consolidates important expertise in the area of environmental health, hazard assessment and investigation in an agency where now those resources are distributed at least over two separate agencies.

We oppose the removal of Food Safety, Drinking

Water, and Shellfish Monitoring out of Public Health, into the Environmental Health category. Public Health officials feel that, and know, that a broad scope of environmental problems, what goes in our nostrils, what goes in our mouths, those things ought to be overseen directly by a public health agency.

How you regulate landfills is a separate issue. But we should be clear on that.

We are very much supportive of name-based reporting for HIV/AIDS, and the establishment of a statewide immunization registry.

Thank you very much.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Sam.

PANEL MEMBER KARP: Co-Chair Kozberg, Members of the Commission, good morning.

Again, my name is Sam Karp. I'm the Director of Health Information and Technology at the California HealthCare Foundation.

The Foundation is an independent philanthropy committed to improving California's health delivery and financing system.

I've been invited to testify this morning about the specific recommendation on transforming eligibility processes. Our testimony reflects five years of experience

in attempting to improve the enrollment in public health insurance programs in California.

We financed and built the Health-e-App System that automates enrollment in the Healthy Families Program. We licensed it to the State, for its use, at no cost.

I want to make four points. The first is that we concur with the CPR finding that the current enrollment systems are inefficient, outdated, and often serve as a barrier to access.

You know, in the year 2004, in a State that leads the country in the use of information technology, to require a family to come into a welfare office and spend three hours to enroll in a single program no longer works.

Second, the internet, and not just the internet, other technologies, like interactive voice response systems that are used in every other area of our society, and other parts of State government, could greatly be used to remove some of the barriers to access to create more public access and create much more efficiency.

With more working families receiving benefits today, creating the ability to automate eligibility application in off hours, from libraries, from home, or places where individuals work would be a tremendous benefit.

We think that there still needs, though, to be choice for applicants. They still need to be able to see a

human being, if they need to.

That said, our third point is that technology solutions alone are not sufficient. We need to simplify eligibility rules. We need to streamline eligibility and paperwork requirements. We need to reduce required office visits. And we need to be able to use information that's collected for one program to determine eligibility for other programs.

The fourth point I make, and you might be wondering, do low income Californians have access to the internet? The answer is yes, and in increasing numbers.

A study that we commissioned, by the Pew Internet and American Life Project, found that 45 percent of low income Californians, with an income, a household income of $30,000 or less, have access to the internet.

A study funded by the Bill and Melinda Gates Foundation found that 71 percent of persons without computer access at home are using libraries to gain that access.

So in summary, let me say that California needs to better align its policy, a commitment to eligibility, with the reality of how complex these programs are to access, and how complex they are to administer.

And to the extent that budget realities require hard choices, we believe it's preferable to save money by improving business processes than in reducing eligibility

rules, by cutting roles, or by further reducing the already low payments to providers.

How this system should be built and who should operate it are certainly up for debate. But the need to do it is immediate, the need to do it is indisputable.

The CPR recommendations create an opportunity for us to take action. With 1.5 million children uninsured in California, two-thirds of them eligible for the Medi-Cal Program or the Health Families Program, we need to find a better way to help those families get their children insured.

Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Barbara, and if you could pull the mike very tight to you.

PANEL MEMBER KONDYLIS: Thank you. Good morning, my name is Barbara Kondylis, I'm a County Supervisor in Solano County, and I'm testifying today on behalf of the California State Association of Counties.

I serve as the Vice Chair of the CSAC Health and Human Services Policy Committee, and also am Co-Chair of the CSAC Family Violence Task Force.

Thank you very much for the opportunity to appear before you today and to provide the Counties' perspective on the CPR. Counties are very supportive of a more efficient

and effective delivery service system for health and human services.

CSAC currently is undertaking a comprehensive approach in reviewing the CPR. Each of CSAC's six Policy Committees will review the report and make recommendations to CSAC's Board of Directors. This process is just getting underway with the Association, and as such CSAC does not have formal positions or recommendations on many of the suggestions in the CPR.

However, we are in a position to provide our initial reactions and suggestions, based on our existing policies.

California is just one of the approximately dozen states where counties administer and deliver health and human services as an agent of the State.

I would like to emphasize that the county-based model used in California is not the norm nationally. California counties provide a huge array of health and human services to the residents of this State. Thus, many of the recommendations in the CPR would undoubtedly impact service delivery at the county level.

I will begin my direct comments on the CPR by first discussing the reorganization, and then we'll touch upon our initial reactions and suggestions to some of the policy recommendations.

On reorganization, I must first begin by saying that we praise the Commission for the recommendation that an Office of Intergovernmental Affairs be established with the Governor's Office.

CSAC appreciates the recognition that counties do, indeed, have a unique relationship with the State and that relationship needs to be formalized in the State structure.

CSAC has not completed a detailed analysis of the Health and Human Services reorganization and how it may affect California counties. However, one point that I must underscore is that whatever structure Health and Human Service Agencies take at the State level, it must provide a formalized relationship with county government. Counties are partners with the State in delivering the Health and Human Services Program. Any reorganization must reinforce this.

As the Chair of CSAC's Family Violence Task Force, I also must encourage the Commission to ensure that reorganization encourages collaboration and integration between justice and Health and Human Service Agencies on issues of family violence.

I will now provide remarks on two of the policy recommendations, the realignment proposal and the proposal to transform eligibility processing, which seems to be the two biggest concerns today.

Counties are very willing to have a discussion with the State about another realignment of programs. We concur with the recommendation that the Governor convene a working group on this issue.

CSAC will participate in any workgroup convened by the Administration on realignment. We view the proposal and CPR as a good starting point for a discussion of realigning State and county responsibilities. However, the details will be important in crafting a workable realignment scheme.

The CSAC has developed a set of principles to guide counties in the case of another realignment, when the then Governor Davis proposed the second alignment in 2003-2004. These principles have been submitted with my testimony.

I would underscore the following points; revenues must be adequate, there must be a dedicated revenue source, and there must be local control and flexibility for discretionary programs.

Our initial analysis reveals a number of technical questions about the realignment proposal.

And I'm running out of time so I'm going to speed this up.

However, they will require a great deal of policy and fiscal discussion, and creativity.

On transforming eligibility processing, our

analysis of the proposal to centralize eligibility for Medi-Cal, CalWORKS, and Food Stamps reveals that the proposal is incomplete. While the proposal points out a number of problems with the current administration, it does not provide any analysis of the reasons for these problems.

In order to streamline eligibility processing, we believe that you must begin with an analysis of why the programs are so difficult to administer.

With that in mind, CSAC believes that the discussion around eligibility should be reframed to first examine what makes eligibility determination so difficult.

Again, I'd like to thank you for the opportunity for doing this, and CSAC looks forward to working with you in the future to resolve these complex issues.

Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Will.

PANEL MEMBER LIGHTBOURNE: Good morning, I'm Will Lightbourne, President of CWDA.

First, I'd like to emphasize that we concur with the importance of --

COMMISSION CO-CHAIRPERSON KOZBERG: Can you pull the mike closer?

PANEL MEMBER LIGHTBOURNE: Certainly.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

PANEL MEMBER LIGHTBOURNE: We concur with the importance of efficient, effective, accountable delivery of public service. And in fact, over the years we have been the primary sponsor of many of the initiatives to simply, streamline, and make more effective the programs that we operate.

We've had some success with these initiatives. Over the past two years California has gone to being one of the worst administrators of food stamps in the country to being one of the best, and has been recognized as such.

Similarly, the counties are working very closely with the State to implement the accountability and outcomes system created by Assemblyman Steinberg's pathbreaking AB363 Legislation, which we supported.

These successes illustrate what can happen when the government, at all levels, focuses on improving efficiency and effectiveness, and uses technology to help get there.

CPR obviously looks in the same vein at what can be made effective and what can be made less costly.

Because time is limited, I will focus on the two areas that are most significant to the human services area, the eligibility transformation issue and the realignment of a couple of local programs.

In the area of eligibility, we've been a long-

standing advocate for simplification, consolidation, coordination for low income, California families.

And the CPR recommendations for simplifying these programs is the right idea. However, the report misses the opportunity to raise the real issue regarding efficient and cost-effective processing, which is the almost unfathomable complexity of the programs as they now operate in California.

Three decades of well-meaning, but uncoordinated, unstrategic, incremental policymaking by the State, the federal governments, and the courts has led to a serious problem. The programs are too complex, too confusing, and too unwieldy to be administered with any efficiency, regardless of who it is who administers them.

We must begin with the issue of program simplification, the what, and only then move into the question of who, who does it.

The CPR lumps these two questions together and focuses primarily on the who, not the what. It's flawed.

As just one example, let me illustrate the differences between the Medi-Cal and the Healthy Families Program. It was referenced earlier in testimony of the apparent cost difference.

Attached to our written testimony, supplied to you, was a chart that illustrates the differences in the

program components between the two. We completely support the notion of simplifying the Medi-Cal Program so that it can be as efficient and effective as the best aspects of the Healthy Family Programs.

And as we enter this discussion, we are open to the question of where best the programs should then be administered, but only once the what is settled should we get to the question of the who.

In the area of realignment, the issue of Child Welfare Services and Foster Care being realigned to counties has come up previously, in prior administration proposals. We've looked at it closely. And there is an underlying logic in that these programs are integrally woven into the local service networks.

However, that said, there are issues that still have to be addressed and resolved. For example, at what level are we talking about realigning the program? Is it the current program, that is underfunded by every standard and which does not in any case meet the minimum state or federal standards, or is it a program funded at the case load standard, identified by the Legislatively-mandated SB2030 Work Load Study in the year 2000. That's a huge question that we would have to resolve.

Second, how would we in fact align program authority if all of the cost responsibility's at the local

level? If the State is still the one making all of the decisions around program requirements, or negotiating with the federal government, or handling lawsuits, then we would have an imbalance that we would have to rectify.

Similarly, the CPR, itself, while talking about realigning child welfare to the counties, proposes a State level Foster Care leadership Czar role, which I think it's just indicative of the tensions that we would have to resolve somewhere.

We consider these sorts of questions solvable, but they would have to be approached honestly, and maturely, and in a problem-solving vein.

To conclude, I'd like to just emphasize that I think we share the same underlying goals. We're committed to being part of the conversation, and particularly to the next step of participating where we get into the sort of roll-up-our-sleeves and work on the real details of what it would mean.

Thank you for the opportunity.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Stephen.

PANEL MEMBER MAULHARDT: Good morning, Madam Chair, Members of the Commission.

I am Steve Maulhardt, I'm an Executive Vice President of Aegis Medical Systems. We operate the largest

network of narcotic treatment programs in California.

I am here, representing the California Association of Alcohol and Drug Program Executives today, as a Board Member.

CAADPE is a professional association of community-based providers throughout the State, operating in approximately 300 sites, and serving approximately 200,000 clients per year. CAADPE is the only statewide association representing the full continuum of care.

We believe that the CPR report is a very worthwhile effort in government improvement, and we applaud your efforts in these hearings.

We are impressed with the proposal's related eligibility simplification.

But in the interest of time, I wanted to focus on two issues that are of concern to us, specifically Recommendations 15 and 21. Recommendation 15 related to the merger of the Department of Alcohol and Drugs with the Department of Mental Health, and 21 related to consolidation of licensing.

We believe this could endanger the citizens of the State, diminish well-established collaborative efforts, and pose potential serious fiscal problems in the Federal Block Grant Programs, and our managing of our maintenance of effort requirements.

Undetected and untreated substance abuse impacts almost every public agency and imposes significant costs on healthcare, and other State agencies, as well as community programs and services.

According to the California's Little Hoover Commission's 2003 report, the annual economic impact of substance abuse to our State is a staggering $32.7 billion for costs of healthcare, social services, and criminal justice system, as well as the losses due to crime, and diminished productivity, and spending on prevention treatment, and law enforcement.

Therefore, the need for a strong, visible, effective leadership in California's State Substance Abuse Agency is critical.

The California Performance Review Commission based its recommendation to merge ADP and DMH on faulty and biased data, we believe.

In its report, the Commission incorrectly cited the prevalence of co-occurring disorders among individuals with serious mental illness at 41 percent.

The latest national figures on co-occurring mental illness and serious substance dependence would indicate approximately 12 percent.

It overstated the relationship between mental illness relapse and substance abuse.

It failed to equally employ citations from experts and organizations, and the providers of substance abuse in the field, with citations used from the mental health field.

It failed to compare California to larger, more diverse states that are far more comparable than the State of Oregon, which was the majority of the data that was presented. The States of Texas, New York, Florida, Michigan, and Ohio, for example, are more comparable and they were not utilized. And the Department of Mental Health and the Department of Alcohol and Drug Abuse have not been combined in those states, even though similar efforts have gone in those states related to reorganizations of government.

The report failed to take into consideration the impact that a merger would have on Federal Substance Abuse and Treatment, or SAFT Block Grant Funding.

A vast majority of the funding in the State actually comes from the Federal Block Grant System, and it is important that the State maintain its maintenance of effort in order to continue to receive those funds.

Mental health funding in California is focused almost completely on persons with serious mental illness or serious emotional disturbance, while substance abuse funding focuses on serving everyone with dependent or abuse problems.

Consolidation of ADP and DMH subsumes the smaller department within the larger one, threatening the maintenance of effort requirements and reporting required to the SAFT Block Grant process.

It failed to consider that State Substance Abuse Agencies, such as those in Florida and New York, typically find that consolidation of a Mental Health Agency, in particular, significantly diminishes their ability to promote effective substance abuse services and policies, and makes it even more difficult to deal with the most important co-occurring disorder, criminal justice.

Collaboration, not consolidation, with the State Substance Abuse Agency, as an equal partner, is of critical importance for the State.

It failed to consider the treatment providers and the staff in substance abuse treatment require certifications that are very different from those in mental health treatment.

It failed to take into consideration the five recommendations of the Little Hoover Commission, in its March 2003 report, "For Our Health and Safety, Joining Forces To Defeat Addiction."

It ignored the most essential intercollaboration efforts with other State agencies and departments that also have responsibility for delivery of substance abuse

services. These include Education, Social Services, CalWORKS, TANF, California Youth Authority, and the Judiciary.

To achieve effective interagency collaboration the Substance Abuse Agency must be highly visible, relatively autonomous, and not completely subsumed to any agency that does not fully share its priorities and mission.

In conclusion, public support of AOD-specific system approaches is best maintained by a separate State Department of AOD Programs.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you, it's time.

PANEL MEMBER MAULHARDT: The landslide passage of Prop. 36, in 2000, reflected the voters recognition and interest in greater visibility of substance abuse services, not less.

Thank you for the opportunity to present our views. We look forward to a continuing dialogue with the Commission and the Administration.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Dan.

PANEL MEMBER SOUZA: Good morning, Madam Chair and Members of the Commission.

My name is Dan Souza, I'm the Behavioral Health Director for the County of Stanislaus, and I'm here to

provide testimony on behalf of the California Mental Health Directors Association.

We also appreciate the work of the Commission, and very much appreciate the invitation to address you.

Regardless of the structure of State government, it is imperative to ensure that the values that underlay the Community Mental Health System in California are maintained. These principles and values include consumer choice and self-determination, the belief that recovery from mental illness is possible, that prevention, early intervention, education, and outreach are effective, that treatment works, that cultural competency is essential in the delivery of services, that consumers and family members must be involved in policy development, and that stigma and discrimination have no place in our society.

With that as a background, we'd like to address five specific recommendations from the report.

The first has to do with the merger of the Department of Mental Health and Alcohol and Drug Programs. From a purely philosophical perspective, we believe that combining the two departments makes good sense. The reality is that a high percentage of the population served by Community Mental Programs have both serious mental illness and substance disorders.

Many county mental health programs and alcohol and

drug programs have been consolidated in recognition of the need to provide more integrated services to their clients. At this time, almost 40 counties in California have combined programs.

However, there are many barriers to overcome in successfully integrating these services. Many of these barriers, as have been noted, have to do with state and federal laws. Simply combining departments will do nothing to provide more effective or cost-effective services. It also does nothing to solve the serious underfunding that currently exists for both alcohol and drug and community mental health services.

Consolidating the two programs, without addressing the problem of underfunding, will not necessarily improve services.

And finally, if this recommendation is adopted, we believe it is very important that the very distinct expertise to operate each of the programs, and the funding streams related to them, be maintained.

Our second comments have to do with the recommendation regarding realignment of local programs. We support, along with our parent, CSAC, the convening of a workgroup, and we have no specific position on the issue of realigning mental health. Though we do have some general comments related to that.

First, it is not clear in this proposal which "remaining State-funded mental health programs" will be realigned. We do see that EPSDT is included. But we do not see mention of the AB3632 program, which is a Federal Education Entitlement Program that counties are currently required, under State Law, to manage.

Without the ability to control growth, manage case loads, and similar options for the counties, it is a great financial risk for the county. The risk must be commensurate with the level of funding that goes along with it.

Finally, there must be some opportunity for continued growth of funding, because that is one of the current problems that exist with community health programs.

Our third comment has to do with licensing and certification. We believe, like many of the others that have spoken here today, that this recommendation has great potential to improve services for certain populations, those who are duly diagnosed in facilities which require dual certification, and especially for adults with serious mental illness, who reside in community care facilities.

Our third comments have to do with the creation of a new Center for Health Purchasing, under the Department of Health and Human Services.

We feel we do not have enough information to

comment on whether the new Center for Health Purchasing would be beneficial to the many clients served by the community mental health system.

In particular, one of the issues that is not clear, but that is of significant relevance to county mental health programs, is whether the carved out, Medi-Cal, managed care mental health plans would be part of the new Center or remain within the Department of Mental Health or the new Center for Behavioral Health.

We feel strong that responsibility for State oversight of the Medi-Cal mental health carve out must remain with the Department of Mental Health or the Center for Behavioral Health.

The program is highly complex and requires specific expertise at the State level. CMGA, and its member counties, have good working relationships with current DMH staff and find DMH to be generally very responsive to the other State agencies with whom we do business.

And finally, our last comment has to do with Recommendation 17, "the Governor should work with the Legislature to eliminate the two remaining city level health programs."

We have taken no position on this matter. However, we would urge the Commission to carefully consider what is in the best interest of the clients being served by

the city programs.

Thank you again for the opportunity to address you, and CMHD is able and available to work with anyone regarding these recommendations. Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

We will now be taking questions from the Commission, of the Panel.

And I also wanted to point out that in the back there are computer terminals, so that you, in the audience, can register your thoughts, and they will go into the transcript of this session. Thank you.

And we'll start with J.J., and then Dale, and then Pat.

COMMISSIONER JELINCIC: Mr. Lightbourne, there's a proposal here to essentially bring eligibility to the State level, then contract it out. Forgetting the social risks of being wrong, economically, if that were brought to the State level and then it turned out to be an error, what would be the cost of recreating that infrastructure to move the eligibility back? I mean, what's the cost of being wrong?

PANEL MEMBER LIGHTBOURNE: I don't really have the answer to that. I mean, I assume it would be significant. One assumes that the cost of moving it to the State, in the first place, would be a fairly intensive, protractive process, it would have a host of cost sharing implications.

Counties have sunk costs in facilities, in systems, in equipment, et cetera. There would have to be some method of recognizing and reimbursing that.

And then if a subsequent decision were made to reverse course, there would undoubtedly be costly.

COMMISSIONER JELINCIC: Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Dale Bonner.

COMMISSIONER BONNER: Yeah, this is a question to Mr. Souza and Mr. Maulhardt, I believe, and it relates to Recommendation 15, and the consolidation of the Mental Health and Alcohol and Drug Programs.

And I sensed a little bit of disagreement among the two of you on the merits of that proposal.

And Mr. Maulhardt, you had taken issue with some of the data that was used to support the recommendation, and I suppose that's fair game.

My question really is, are your respective positions on that recommendation, are they philosophically based, you know, is there a philosophical issue there about the difference between those programs? Is it a programmatic difference? Is it a clinical difference? I mean, what's at the root of your respective views on that recommendation?

PANEL MEMBER MAULHARDT: Well, I think that there are a couple of things going on. Mental health was realigned 10 or 11 years ago, and it is a system that is

more accustomed to being at the local level.

Alcohol and drug services are also provided at the local level, and it is true that a vast majority of the counties in the State of California have a combined department, or combined leadership for mental health.

But my issue is more in the area of funding and what makes sense for continuing to maximize the federal dollars that you can get. And without having a focused effort at the Department of Alcohol and Drug Programs, I think we put at risk a lot of that federal funding.

And in fact, mental health has a very low proportion of federal funding, and I think that part of the reason is that the Mental Health Department, at the State level, is just allocating funds, they aren't really advocating. So philosophically, we disagree.

The California Association of Alcohol and Drug Program Administrators, I think agrees with my position, and you have some written testimony on that, that was provided.

PANEL MEMBER SOUZA: From a purely philosophical perspective, I think our belief is that if you look at the individual client that we serve, who comes in with problems, in their mental disorders and alcohol and drug problems, the notion of having to have people go through different doors or different programs, and have fragmented or less than integrated services just isn't good customer and client

service.

Integrating services to that population makes much more sense when you look at it from a purely client perspective, and it has been done in many counties.

For a practical perspective, those 40 counties, who already have combined programs, are dealing with two separate State agencies, with two very different cultures. It is true they are guided by many different state and federal laws. But the cultures, in themselves, affect, and then individuals having to deal with two separate people for very similar matters creates inefficiencies at the local county level.

And finally, just to note the issue of federal dollars. Even though there are more federal dollars that proportionally go into the Alcohol and Drug Program, the State Department of Mental Health does administer a significant amount of Federal Block Grant dollars.

In just our county, alone, the amount of federal dollars for mental health equals the amount of drug and alcohol dollars that comes into our county. So our department administers, from two different departments, about equal amounts of federal dollars.

COMMISSIONER BONNER: So do you agree with the suggestion that consolidation would put federal dollars at risk?

PANEL MEMBER SOUZA: I think that would depend on the ability of the State Department's Behavioral Health to develop the expertise, as we recommended, to manage the different kinds of requirements that the federal funds require for each of the two funding streams. And it's mainly a matter of expertise at the State level to do that.

COMMISSION CO-CHAIRPERSON KOZBERG: We have the following Commissioners that want to ask questions, Pat Dando, Denise Ducheny, Russ Gould, and Steve Frates. Have I missed anyone?

Thank you. Pat.

COMMISSIONER DANDO: Thank you, Madam Chair. I also want to thank the panelists, all of you were very informative and I appreciate your being here today.

I want to just make one comment and then I have a question. A couple of the panelists actually talked about that it would be important for us to determine what the program should be before we determine who should administer the program and where the program would be placed. And I think that would be sage advice for us all to remember as we continue these hearings.

My question is to Barbara. Barbara, you had mentioned, in your comments, your concern with family violence or domestic violence, but I sense you didn't have enough time to elaborate on that. Would you mind speaking

to that just a bit?

PANEL MEMBER KONDYLIS: CSAC, of it's six Policy Committees, we have addressed the issue of family violence by combining the areas of criminal justice and health and human services into a special task force, recognizing that issues around family violence, child abuse, partner abuse, and elder abuse affects the family all at once and cannot be looked at or addressed either by criminal justice systems alone, or health and social services alone, they're so intricately connected. And the emphasis is on how you prevent family violence, which I personally think is the number one public health problem in the State of California. So we're working to do that.

COMMISSIONER DANDO: Thank you.

PANEL MEMBER KONDYLIS: Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Denise.

COMMISSIONER DUCHENY: They all raise a series of questions. I guess my focus at the moment would be, with this particular panel, a little bit on the realignment questions, because I don't think there's a clear realignment discussion here. And I think even just hearing this dialogue, the mental health and alcohol issues, I mean in some ways it makes sense to consolidate them at the local level, whether it makes as much sense at the State level is kind of different

And it goes to this question of the streamlining of the applications. I mean, I think a lot of us, for a long time, have been trying to figure out how to get one form, or at least the eligibility to be clear. You could give people, you know if you could figure one, it's like a Student Aid application now. If you could get one form that lays out all the income and you can say, okay, that means you're eligible for TANF, you're eligible for Medi-Cal, you're eligible for food stamps, or you're only eligible for one or two of the other ones.

And I think the technology of it's important, and I don't know what difference it would make if we -- I don't quite understand why we'd want to move it to the statewide level, as opposed to the county level, as long as the criteria was the same for every county.

And then the question of IHSS, Child Services, what you just said seems to me to argue for some of these things in the realignment discussion. I mean, the preventive stuff, our best probation preventive things, our drug court systems that work with the drug and alcohol providers, I mean all of those things seem that they have been done at the county level.

And did you all have a comment on the IHHS MIA issue from CSAC?

And my final one would be for the mental health

folks. The piece that's missing from this Panel and some of the overlap from other departments, that's not here, is education. Mental health, obviously in San Diego that's become a real hot topic these days, the question of providing mental health services through education.

But it also goes to the question of childcare and welfare folks, and maybe should education be providing childcare and should the county be providing the mental health services for students?

So I'll throw them all out at once.

PANEL MEMBER KONDYLIS: Well, I'll start. I think counties do a very good job, given the limited resources and the economic times, of providing services. Those first-line employees, who are out there face-to-face with clients, I think really care about what they're doing. So I think we have to be very careful about realignment where that connection is removed.

COMMISSIONER DUCHENY: But you can just effectively administer an internet program and a single eligibility criteria; right?

PANEL MEMBER KONDYLIS: Right. As someone said, that's just part of the paper problem. What counties are concerned about is providing effective quality care for the people who are under our charge.

And as was just stated, we have to figure out what

the problem and the impediments are, and at the very end decide who's going to do it. But we do need that funding stream. We can't operate the way we do any longer.

PANEL MEMBER SOUZA: In regards to the mental health issue, if you want me to address that, actually education programs and county mental health programs have worked very effectively over the last, almost 20 years, to provide services to handicapped and disabled students.

The problem that's raising itself in San Diego is not an issue of collaboration or ability to work together, it's a problem of an unfunded State mandate where counties are --

COMMISSIONER DUCHENY: Versus an unfunded federal mandate, thank you very much.

PANEL MEMBER SOUZA: That's right, it's a federal mandate on education, passed onto county mental health programs, in which the mandated funding has been removed for the last three years, and which counties have absorbed at a huge debt to provide this service. And they also have no ability to manage it, control it, or set limits, or new rules or regulations about it.

COMMISSIONER DUCHENY: For the counties, I think one question is sort of the medically indigent issue. I mean, how inconsistent are the counties in actually providing the medically indigent. I mean, most of you are

hurting big time to do that, or the hospitals are in this county, the hospital eats it rather than the county. And some other counties, as well, are just absorbing the costs just through -- it's unreimbursed medical care for the hospital because the county refuses to contract to pay enough services to actually pay for the medical care.

But that versus IHSS, for instance, in a realignment discussion, is it possible for the counties to actually fully fund the medically indigent for the hospitals, on a consistent basis, so that each county is providing the same level of services, or is that just something the counties will never be able to do and maybe that's the one we ought to --

PANEL MEMBER KONDYLIS: If I might, I'm not speaking for CSAC, I can speak specifically to Solano County. I think all counties do it differently. But in Solano County we formed a coalition with Yolo and Napa, with a capitated healthcare system, where everyone gets to choose the doctor of their choice. And that, because it's capitated and managed so well there's money left over, and we're looking at trying to fold the indigent healthcare into that system and to work it out.

But again, with the fluctuations in funding, the Partnership Health Plan, as time has gone on their level of funding is diminishing so that these kinds of solutions

won't work.

But if they were instituted on a statewide level, I don't see why you couldn't do it that way.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Russ Gould.

COMMISSIONER GOULD: Thank you. You know, on the question of eligibility and enhancing the process there, a comment was made that for all good intentions there have been incremental changes to these programs, which adds to the complexity and, therefore, the cost, and sometimes confusion on eligibility.

I'm struck at the same time, in looking at other states that were included within the report, they talked about Pennsylvania, New York, and even New York's cost for the three programs that are described are approximately half the cost of the State of California's. I assume they have had similar problems. Did they go through a process? Is anyone familiar with what the other states have done in order to achieve the efficiencies?

PANEL MEMBER LIGHTBOURNE: If I could take a shot at that. First, they didn't create it in as complicated a fashion as we did in California. We overcomplicated it.

Secondly, they have been probably more effective at trying to have simplification over the past few years.

Let me just give you an example, using just the

Medi-Cal Program. There are currently three separate Medi-Cal Health Programs for children, depending on whether they are age 0 to 1, 1 to 6, or 6 to 19. So depending just on that factor, different children will wind up in different programs. If there are more than one child in a family, that are within different age groups, you've now got a very complex thing.

For the last five, six, seven years CWDA, and Senator Figueroa have been trying to collapse just these three programs into one, and haven't been able to do so.

In total, we have more than 150 Medi-Cal Programs in California. I mean, this really is a matter of is there a political will to simplify a system.

COMMISSION CO-CHAIRPERSON KOZBERG: Steve Frates.

COMMISSIONER FRATES: I think this is directed to Mr. Maulhardt and Mr. Souza, but anybody else who might know. One of the things that I think needs clarification is the percentage of people in the mental health system, in whatever guise you define it as, are people who are substance abusers, drug or alcohol abusers and, of course, the obverse of that question is how many people get in the substance abuse situation who also have mental health problems as well, what degree of overlap exists?

And I rather suspect this is going to lead to some discussion as to how the Criminal Justice System winds up

with the end product, residue out of that as well, but I'll leave that for Sheriff Carona.

PANEL MEMBER SOUZA: I think the study cited, Mr. Maulhardt, is a national study. Quite frankly, the treatment population that we serve, the people that actually come in our doors, we believe is closer to what was cited in the introduction, of at least 50 percent of the population have overlapping disorders.

We do serve the most seriously of the mentally ill in California, people with bipolar disorders, schizophrenia, and others, so they are very susceptible to having their alcohol and drug disorders seriously affect their mental health treatment.

And yes, without treatment oftentimes individuals will end up in the Criminal Justice System, either lack of treatment for mental illness or lack of treatment for alcohol and drug problems. When you have both, though, the risk of ending up in the Criminal Justice System increases dramatically.

Many people that we see homeless, on the streets, who are labeled as homeless mentally ill, oftentimes have serious alcohol and drug problems and it's hard to figure out which is the most related to their being homeless at the moment.

I can't really speak to the issue of how many

people in the alcohol and drug system have undetected mental disorders. As a mental health professional, I suspect it's significant, especially when you talk about the adolescent population in California who needs alcohol and drug treatment.

And as we all know, it's a very underfunded service, very few kids in California get adequate levels of alcohol and drug treatment because of funding. But many of those also have untreated or undiagnosed mental disorders.

COMMISSION CO-CHAIRPERSON KOZBERG: Leland Yee.

PANEL MEMBER MAULHARDT: I would say that the 12 percent figure relates to the people that are diagnosed as severe and persistent mental illness, so that's a category.

In our population, we treat about 6,000 patients in our particular system, I'm not sure about CAADPE. And I would say that a very high percentage of those folks have some sort of mental disorder. It's not the persistent sort of mental disorder, it may be depression, it may be ADD.

And we train our counselors to deal with that, because you have to. I mean, you have to try and work on all of the things that make that person an addict or make that person unstable.

I think that the answer though is collaboration, it's not combination of the administrative function, it's more collaboration between mental health and alcohol and

drug services.

COMMISSION CO-CHAIRPERSON KOZBERG: Leland Yee.

COMMISSIONER YEE: Sure. This is a question opened up to the different professionals, the mental health, the drug abuse, and the county welfare program, and then maybe the person from CSAC.

There's a lot of discussion, there's a lot of characterization that the system's just broken, it doesn't work. It's confounded, the funding stream's not there, the eligibility criteria's all messed up. And so there is, I think, some discussion about whether or not the role of the State should in fact be one of just simply coordination and facilitating, and to leave the operational side to the local counties. And maybe even the eligibility criteria, maybe then even the funding stream, and so on.

Is that a scenario that your respective leadership, in your local community, and as a profession, is that the direction you think the State should be moving in?

PANEL MEMBER LIGHTBOURNE: If I could start it, Commissioner Yee. I think, from CWDA's perspective, I don't think we necessarily do think that way. I mean, as we view it, we're saying in the eligibility area we don't know who should do it.

What we're saying is first let's decide how we want to simplify the program and then look at it and figure

out what makes sense at that point. It could be local, it could be state, it could be a local/state arrangement. It might vary for some of the small counties versus some of the bigger counties.

And there may be a role for private sector functioning in there. I mean, we don't foreclose anything, from our perspective, from that conversation.

In terms of Child Welfare Services, there we feel strongly that that should be, to the extent possible, county operated, although with the resolution of issues of resources and the resolution of the issues of authority to change, amend, recreate the program being more clearly, explicitly shared between the counties and the State.

Some of the other programs that are discussed in the realignment proposals, I think there may indeed be a logic to IHSS being something dealt with more at a State level than it is not. But again, I don't think there's a single answer.

COMMISSION CO-CHAIRPERSON KOZBERG: Sheriff Carona.

COMMISSIONER CARONA: I'd like to direct this to Mr. Mayer, and by way of a request, not by way of a question or statement. Having read through the findings, and the recommendations that have come forward and, more importantly, the testimony today, I think it's inevitable

that the Little Hoover Commission is going to be getting recommendations about some type of reformation for the healthcare in the State of California.

As an individual who, as one of my colleagues mentioned, is the end user when the healthcare system runs down, I run the sixth largest jail in America, I have 6,000 inmates in there, and I can quote numbers about the percentage that are mentally ill, and the percentage that are addicted to drugs and/or alcohol.

Notwithstanding those percentages, I would suggest to you that as you do your analysis of what needs to be done, a comprehensive strategy for healthcare in the State of California, that you need to factor in those costs that are being absorbed by those of us in the Criminal Justice System when clients are not being served in the mental health community, when we don't take care of those who have chemical dependencies in our communities.

And if we don't invest those dollars up front, you invest them on the back end in a more expensive format, jails or state prisons. And frankly, it's a bad way of doing business. It's disingenuous to those who need the services, it's disingenuous to the public.

And I think when we start to factor this out, and you're looking at it from the Commission's standpoint, a recommendation coming forward, the basic business model of a

return on investment, that a return on investment has to be quality dollars invested up front, the savings will be there on the back end.

(Applause.)

PANEL MEMBER MAYER: Sheriff, I think that's exactly what the Commission has done as it's gone through this work. In fact, when we did mental health, we spent a lot of time with Twin Towers, and other folks, trying to understand how they would change their programs. And we advocated, in that case, how we could better tailor State dollars in order to prevent people from ending up in jails simply because they have not been treated for the mental health.

So I want to assure you that's actually where the Commission has gone down this line, as how do we make a better use of this dollar today to prevent the needs. And we'd be happy to distill that testimony, if it isn't clear for you, with what you have in front of you.

COMMISSION CO-CHAIRPERSON KOZBERG: Yes, Barbara.

PANEL MEMBER KONDYLIS: And there was money to do mentally ill diversion programs. And I know in my county we built a facility so that mentally ill people, who don't belong in jail, would have a safe place to be housed and so they could get the treatment.

We put up the money, the matching money, did

everything, but then the State ran out of money. So something that was good and looked like it was going to work, because the money dried up it went away, and so we're back to square one, where you're a mental hospital, in essence.

COMMISSION CO-CHAIRPERSON KOZBERG: The last question is Mayor Beverly O'Neill.

COMMISSIONER O'NEILL: Actually, I'm pleased to have a comment after the Sheriff spoke, because that was my point in bringing forward the fact that the Little Hoover Economic Impact Statement on the Criminal Justice, on the Social Services, on Healthcare, at $32.7 billion, caused by drug addiction or alcoholism, is certainly something that we have to pay attention to.

And I don't know if they counted the person that had to leave the house to get a drink because they were addicted or drugs, and got killed, they got killed and it's a car accident, but they really were killed because they were addicted.

And so I think we have to do this on the front end. It's the same as in education. If you don't educate people, they're going to end up using more services of the State of California. And I certainly feel that we need further study on the combining of these two.

COMMISSION CO-CHAIRPERSON KOZBERG: Yes.

PANEL MEMBER HORTON: As a Public Health Official, I can't resist the temptation here to also point out that Prevention Services fits into this same framework, that we can prevent the dollars that end up getting spent in the jails by a more effective and aggressive approach towards prevention of alcohol and substance abuse disorders.

(Applause.)

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. I want to thank the Panelists, you've done an excellent job.

And we're going to break for lunch, and we're going to try and really eat quickly.

We're going to reconvene at ten minutes until 1:00, where we'll be hearing the Advocates Panel. Thank you.

(Thereupon the luncheon recess was held.)

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A F T E R N O O N S E S S I O N

COMMISSION CO-CHAIRPERSON KOZBERG: We need your full name.

PANEL MEMBER WARD: Thank you. My name is Debra Ward, I'm Deputy Director of the Community Clinic Association in Los Angeles County, and I thank you for this opportunity to speak on behalf of our 42 member clinics in the Los Angeles Basin area, that are predominantly independent, nonprofit, private clinics.

CCALAC, that we fondly refer to the organization, provides primary and preventive health services to indigent and uninsured people living in urban and rural communities in L.A. County, predominantly in the urban areas.

These clinics provide culturally and linguistically appropriate care to thousands of patients every year, including many of the county uninsured.

I come to you today on behalf of our L.A. network of community clinics and the patients that they serve. They serve about a half a million users, and close to about two million encounters per year. They're a large provider of the medically indigent.

Before getting started, I just want to say on behalf of our membership I really would like to acknowledge the work that was done and commend the CPR Team that took on this enormous task, and presented and generated this volume

of documents.

We're still actually in the process of reviewing many of the recommendations, and the ones that will be presented today are preliminary at this point. We do plan to present more detail, a supplemental comment in the next 30 days.

So with that in mind, I'd just like to offer a few comments on the CPR, looking at some of the different recommendations that we have been very supportive of. But overall, I think we've just been really encouraged by the CPR report. We think that many of the recommendations that focus on administrative simplification, the elimination of the bureaucracy, barriers to access, and the enhancements of customer-oriented services is a discussion that is long overdue.

We would much rather take the time to look at some of the internal and things that we can do to look at cost savings within our existing system, than to spend the time on reducing services, which has been a great deal of the time spent on budget cuts.

With that in mind, I'm just going to focus on a couple of different items. One, is the transform eligibility processing. That is a recommendation that we have been supportive of and we feel that this provides access to the application process, could be greater achieved

through the internet, which would allow an application to be completed in libraries, community-based organizations, and one's own home.

So additionally, the recommendation to use a self-declaration of certification of asset for eligible population has the potential to benefit access to care and the service provider network, reduce paperwork on the part of the patients, and the provider, and provides a continued payment source.

Many of our clinic members, as well as our patients, with the enormous amount of paperwork that has to go on in terms of being eligible for these services, has -- I'm sorry, I lost my train of thought.

But the reduced paperwork on the part of the patients and providers will provide a continued payment source.

Just moving on to the Certified Application Assistance Program that was recommended in it, is another one that we think our clinics were involved in that program with Healthy Families, and really support continuing that effort.

Improving the Medi-Cal enrollment process will result in more eligible individuals enrolling in the program. And as a result of that, an increase in enrollment could result in more people establishing a primary care

medical home.

Improvements. We do support, this wasn't a recommendation in the report, but we would suggest that the Administration possibly deputizing workers at FQNCs, and other community clinics, so that they are able to complete Medi-Cal applications on site, and also provide a point of entry for Medi-Cal patients.

Another item is this consolidated licensing and certification function. And this is one we also have been very supportive of. We think that consolidating the licensure is in step with many of the recommendations that we have pursued legislatively, throughout the years, with our State Primary Care Association, as well as working with our existing licensure offices in the local area.

In terms of improvements, it's important that any consolidation proposal also ensure that the surveyors are properly trained, and regarding specific statutory and regulatory provisions.

Other items that we we're supportive of is the realignment issue. We do have a number of concerns regarding that. Our organization works very strongly with our local county and we hope that in the workgroup that is recommended of the CPR, that they include community providers, and patients, and also do an assessment of the human toll or impact of doing a realignment plan.

At this time, my time is up, and I would refer you to the rest of the written testimony. Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Catherine.

PANEL MEMBER TEARE: Good afternoon. I'm Catherine Teare, I'm the Director of Policy with Children Now. Children Now is a nonpartisan research and action organization dedicated to ensuring that children grow up in economically secure families.

And I'm grateful for this opportunity to testify.

We are pleased that the State is engaging in a process to improve the efficiency and effectiveness of State services and to better serve California citizens. We're eager to work with the Commission, the policymakers, and the public toward these goals.

We've submitted written comment on a number of additional areas within the HHS section, but my comments today will focus primarily in two areas, subsidized childcare and eligibility processing.

Our comments on the recommendations related to the subsidized childcare system reflect our belief that the purpose of these programs is twofold, to educate children and to support the work participation of their families.

California Subsidized Childcare System already suffers from a split structure, but its biggest structural problem is its chronic underfunding.

Unfortunately, we don't see that in the main the CPR recommendations related to childcare do much to meet the goals of better service to families and more efficient use of resources.

Specifically, looking at HHS 04, the proposal to simplify the California Subsidized Childcare System to deliver better service, while we believe that the existing split between CDE and the Department of Social Services, in the administration of subsidized childcare dollars should be addressed, the recommendation to merge CalWORKS stages one and two, and put that administration under county welfare departments, we feel does not support the goal of children's education and is in conflict with larger school readiness goals and the quality criteria already developed in the Department of Education through the Desired Results Project.

In many ways, this proposal takes us back to the period before CalWORKS, it's a major reversal in that in splitting the administration of subsidized childcare for families on cash aid, from those not on cash aid, and putting families in cash aid into a system that is less in line with school readiness goals and standards of education for young children.

The proposal also doesn't appear to do much to reduce fragmentation, in that it maintains two separate structures. And for that reason, we don't support it.

The Recommendation B, in that same section, which urges families to join waiting lists when they begin participation in CalWORKS, also doesn't go to the root causes of long waiting lists and seems, in fact, to drop the -- perhaps inadvertently, but to drop the threshold for subsidized care from 75 percent to 50 percent of the State median income, which we think is unacceptable.

Moving on to subsidized childcare quality, the recommendation to reduce reimbursement rate for license-exempt childcare to 50 percent of the current standard, we believe is unacceptable, and it severely harms families most dependent on that care, including families who work irregular hours, don't speak English as their primary language, or have children with disabilities and need of specialized care.

I want to move quickly on to proposals in eligibility processing, in particular, in healthcare. And our comments here are developed in conjunction with the One Hundred Percent Campaign, a collaboration of Children Now, the Children's Defense Fund, and the Children's Partnership.

The proposal in HHS 01 calls for sweeping change in the processing of eligibility for Medi-Cal, CalWORKS, and Food Stamps. And while we see some real opportunities there, we caution the Commission to, as speakers on this morning's Panel noted, to look first at simplifying before

moving into using -- or specifically not to think that we can switch business processes without switching, making changes to the underlying structure of eligibility.

We do think that certain recommendations, among them self-certification of the assets test, goes in the right direction in terms of simplifying the actual eligibility requirements.

We would urge the Commission to go further and look at dropping the assets test altogether, and also looking to self-certification of income. I'm sorry, and paperless income verification.

I'm out of time, so I will stop. But I would only go on to say that we have great hope for leveraging new technologies to improve families' health insurance enrollment. But also caution that none of these technologies, promising though they are, can replace contact with real people, and all require attendant change in eligibility requirements in order for them to work.

Thank you for your time, I look forward to answering any questions.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Lucien.

PANEL MEMBER WULSIN: Good Afternoon, Madam Chair and Commissioners. I want to thank you very much for inviting us to testify this afternoon.

My own background on this issue is that I've been working on it for about 35 years, which I think has Steve Olsen beat just by a hair.

And I particularly would like to make my remarks this morning in memory of Steve Thompson, who passed away this week.

I'd like to address the issue of maximizing federal funding, transferring responsibility for healthcare for low income working adults, fixing the disproportionate share of hospital financing, and changing the way we determine and process eligibility.

I'd like to tell you that I think that they really are all interlinked. I want to start with the issue of the indigent adults, which are county responsibility. They've been county responsibility in California since '82-'83. The funds for them, the realignment funds don't keep up with either the growth in the uninsured or the growth in healthcare costs.

The Prop. 99 funds, which support them, have been going south at a pretty rapid order. And the DSH funding, the Federal DSH funding has really been capped.

So I do think that there are a lot of advantages with county health departments doing this, but the financing with which they've had to struggle mitigates for State takeover.

I would say that the only way the State takeover makes sense is if we can link it up with an increase in federal matching for this population.

States, such as Oregon, Arizona, New York, Massachusetts, and Tennessee, have all secured 1115 waivers to pay half the costs or more of care for this population.

And so if we're going to make this transfer of responsibility, it needs to be linked up with securing federal matching to provide a decent funding level for this program.

But the only way we get a federal matching is if we link it up with another very controversial issue, which is Medi-Cal redesign, which is not part of your agenda. And I would just say to you, that unless we can do so in a creative way, it's tough to get federal matching monies.

Now, the other thing that I want to just point out is you've talked about restructuring the DSH program that pays hospitals for their uncompensated care. I do think it needs restructuring and I do need to say that if we proceed with a State takeover of responsibility, that there would need to be major changes in the way DSH operates because we would be moving from uncompensated care to compensated care, and this would change the whole way that the funds are made available.

Finally, on the issue of simplifying the

eligibility process, I was in Massachusetts when Massachusetts moved from city and counties to state responsibility. It took about four or five years to work that out in the small State of Massachusetts.

I think it's a very good idea to move towards the Healthy Families model. I'd echo what Will Lightbourne said earlier, which is that Medi-Cal, in particular, is an extremely complex program and this isn't done simply. But I think that would be having us going in the right direction.

So I just want to close in thanking you for the excellent work of the Commission staff and the Commission on this, and say that I really hope that you understand that most of these issues, that I've identified, really relate to each other and you can't do most of them in isolation, without kind of far-ranging impacts. So thanks very much.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Carole.

PANEL MEMBER SHAUFFER: My name is Carole Shauffer, I'm the Executive Director of the Youth Law Center, which is a public interest law firm with offices in San Francisco and Washington, representing the interests of children in juvenile justice and foster care.

And I'll try to be quick. And I will say I've been doing this before I needed glasses to see what I'm supposed to be saying.

(Laughter.)

PANEL MEMBER SHAUFFER: Overall, I really wanted to thank the staff of the Commission, who has consulted with us and asked us for our opinions, and actually incorporated some of them into the report, which is unusual for us.

We work on child welfare, and we strongly support the idea that there should be a State presence which controls quality of care in child welfare and which sets a statewide direction. So we applaud that recommendation. We don't totally understand how it would be implemented, but we like the direction.

We are concerned with a couple of other recommendations that seem to go in the opposite direction. Maybe they don't. Again, it's hard to understand without all of the detail.

But realignment of Child Welfare Services, which occurs as an idea regularly, seems to us to go in the opposite direction, since the State would lose the ability to oversee and control county programs.

So we are concerned about realignment for that reason. We're concerned that every other time we've ever tried to do realignment of all the child welfare money, that the feds have said that that's not possible because of a single state agency. And finally, we were concerned because the federal government is looking again at how they're going

to fund child welfare, and this may not be the time to make major changes in our funding scheme.

Secondly, with regard to licensing, just quickly, we are somewhat concerned about moving foster care licensing in with all other licensing, to be one thing. Foster care and child welfare programs are really different because there's only one customer. Well, there's 58 customers, but it's only the government that is the customer.

Therefore, licensing, the licensing regs., the implementation, who gets licensed first, those all are very tied in with the program that you're trying to achieve.

Unlike childcare, nursing homes, et cetera, where the customer may be a private individual.

So just for this licensing, there is some value in a close integration between program and the licensing. It's not simply bricks and mortar. It has to do with do you want more intercity foster homes, do you want more relatives to be foster parents. And if you move this away, I think you lose some of that programmatic advantage.

Similarly, we are concerned about the changes in criminal records and in crimes that would be -- eliminating the waiver ability for certain crimes, particularly for foster homes and relative foster homes.

In many communities people have criminal records and overcome those criminal records, or are involved in

economic crimes. There's been a real danger in trying to not look at the details of what happened, but look at what the charge was, so that many relatives now, and community members and friends have been made ineligible to care for children who would benefit from being with them, and where they would not be dangerous. So that's our second point, or third, or whatever number I'm on.

The last, our final point is on adoption. We applaud this effort to have more children adopted. That is critical. We have to reduce the number of kids in care, they're not all going home.

However, we think an additional recommendation would be that the State should have tighter oversight over the adoption process.

The problem isn't not enough adoptive parents, the problem is that they're not served well when they get into the adoption system. It takes too long, it's too rigid, it is inflexible, and people hear about that and then they are deterred from applying.

So we would like to see more oversight over the quality of adoption by this State Agency, which is going to be looking at quality all together.

And thank you very much.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Marilyn.

PANEL MEMBER HOLLE: We appreciate your invitation to us. It's a lot of work and our folks in our organization are continuing to analyze it and do research.

COMMISSION CO-CHAIRPERSON KOZBERG: Could you state your organization for the audience?

PANEL MEMBER HOLLE: I'm Marilyn Holle with Protection and Advocacy.

Let me start with some of the restructuring stuff. There is really significant concern about dividing disability services into two divisions. Just as we support the recommendations that would foster, whether by combining or other method, greater coordination and collaboration with respect to mental health services and substance abuse services, we are concerned about not recognizing the need for corroboration in other areas.

The number of individuals who are served by regional centers, for instance, who have pretty significant mental health treatment needs. Individuals with physical disabilities, with significant substance abuse problems and mental health treatment needs.

So we really think that there should not be that division. We're also disturbed about the different definitions, sort of suggesting a second-class status to behavioral health services.

Again, in sort of reorganization, like

Carole Shauffer, we have concerns about consolidation of licensing. We really think it's important that the licensing and certification be collapsed together in programs that have programmatic responsibility as well. I think it is essential in order to sort of avoid arbitrariness and rigidity.

For instance, one of the suggestions we had made to Secretary Belshe was to combine both licensing and certification activities for facilities serving regional center clients in the Department of Developmental Services, so people doing those functions are not divorced from the programs and the purpose for the rules, and how to be flexible.

Some of the results of not doing that is you have individuals being kicked out of facilities needlessly, when there would be ways of accommodating a person who needs some small amount of medical treatment. So we're strongly opposed to that.

And again, in sort of reorganizations, we think it makes sense to shift financial responsibility for the IHSS Program to the State. For the IHSS and Medi-Cal Personal Care Services Program, we think its oversight should remain with the Department of Social Services. And that's for historical reasons, and it's important to the community of people with disabilities, who rely on it, that it retain its

social model and avoid that medical model.

As Mr. Gould will remember, back in '92-'93, when we were working collaboratively to access federal Medicaid money into the program, one of the canons we all lived by was preserving that social model, and it should stay where it is. Don't fix what's not broken.

About the strategies for improving eligibility, we believe in simplification. We're not certain whether transferring to the State will do it, but we have some significant cautions.

We think there's a lot the State could do to reduce and make it easier to make disability assessments. But in looking to Healthy Families as a model there's a real problem, because that program, that dual application, completely disregarded the needs of children with disabilities. There's not one question or not one way on that form which would flag a Medi-Cal applicant at being looked at more closely to see if that child had a disability and would qualify for one of the disability-linked programs.

So there's a lot of pitfalls, and in representing individuals who end up losing out in simplification, we really have some serious problems.

We think there's roles for community-based organizations and others to assist in accessing. We support internet. But our clients need access to a real person,

particularly because of their disabilities, and I think it's true of others.

So in opening the door to internet and in encouraging its use, the doors to other means of applying should not be closed or narrowed.

About medically indigent adults, I remember the old MEIA program and I would really support returning to that kind of system, integrating it with Medi-Cal.

I think there's another waiver that should be looked at, it's one being proposed by some of the counties, and that is using some of the unused S-CHIP money and looking for funding from what you save by assisting people in avoiding reaching an SSI standard of disability.

You have the rest of my comments and I'd be happy to answer questions. Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Mike.

PANEL MEMBER HERALD: Thank you. My name is Mike Herald, I'm the Legislative Advocate for the Western -- or a Legislative Advocate for the Western Center on Law and Poverty, we have more than one.

I had supplied some written comments in advance of this hearing, but I have to note that having sat here for several hours today, I've heard several things that have answered questions that we had here, so I'm going to try to

avoid some of that, and probably ask a few different questions that I didn't have on my list at the beginning of the day.

Quickly, Western Center on Law and Poverty advocates to the rights of low income people in California, in the areas of health, housing, and public assistance.

We work very closely with local organizations and legal service advocates at the local level. In the health arena, for example, we work closely with the Health Consumer Alliance, which is a partnership of community-based organizations.

Here, in the San Diego area, we work very closely, for example, with the Consumer Center for Health Education and Advocacy, which is part of the Legal Aid Society here, in San Diego County.

And we hope, later, the Commission will have a chance to hear from them on the local perspective on your recommendations.

We really appreciate the opportunity both to speak to you today, and we really thank the Commission for all the hard work that you've done, and that your staff has done. And we must say that in the area of the health and welfare areas, we think that your team, the leadership that you have with Terri and Bob, frankly, couldn't be better, and we look forward to working with them as we go forward.

Obviously, we are keenly interested in the recommendations of the CPR, because many of these recommendations will have a direct impact on the lives of the poorest people in our State.

And we want to note, right from the beginning, that Western Center stands ready to assist the CPR, and the Governor, to operationalize, I think that's your word, to operationalize the most worthy of these recommendations.

And one of the things that we heard in the morning, that I thought was useful, was that as we came in here we felt a little overwhelmed, there were so many recommendations, in so many areas, that we were concerned about our ability to really provide meaningful participation on so many issues.

Hearing that, for example, that the eligibility and the realignment issues may get rolled into a single workgroup that would go forward, I think is a very good idea and I think would go a long way towards kind of focusing all of our energies in the health and welfare area on some key things that we really could get done and make a major difference, both for the State fiscal issues and for the lives of people that these programs are designed to work for.

And we want to especially encourage the Commission, as they go forward, to make sure that we

continue to hear the voices of not only the advocates, but the consumers are given a chance, through this process, to be part of the work that goes forward.

I'm going to take just whatever minutes, until I get the red card here, on a few of the issues that we wanted to comment on today, quickly.

And I should note, we have supplied a lengthy analysis to Secretary Belshe, earlier this week. It's up on the Western Center website, www.wclp.org. It's our answer to War and Peace, and we hope that the folks in the audience, and the Commission will take the chance to read that.

So I'll just summarize a few of the things that we wanted to make special note of today. First of all, we must oppose the effort to eliminate the $50 pass through for child support. At its most fundamental level, it reduces funds for the lowest income families in our state to be able to survive, pay rent, be able to put food on the table, buy clothes for their children.

But moreover, I'm not sure that the Commission had correctly read the research in this area. We think it's an open question. But we would more importantly note that in the authorization, the issue about child support pass throughs is actually being enhanced. The feds are going to start to return, at least in the proposals in the Senate,

would return federal dollars to the states and increase that to $100.

We think there's really a strong argument for maintaining and perhaps expanding this proposal. And so the notion of eliminating just seems to run completely counter to that.

And then also, we are concerned about the elimination or the folding in, if you will, of the Department of Child Support services into the new DSS, as it is. We're not arguing that what's happened in child support is perfect, we know that there's room for improvement. But I think describing it consistently as underperforming is probably not fair to the incredibly hard work that many people at the State and local levels have done to enhance this program.

We are improving collections. We are doing better, when you compare us to the national statistics. And I think we need to be a little bit more careful with that.

I'm out of five minutes already, huh?

I will just say one last thing on eligibility, the consolidation of eligibility. The question for Western Center, and I think for many of us will be, is what standard are we going to use to determine eligibility. If we're moving to a CalWORKS standard which is going to reduce eligibility for folks on Medi-Cal, we're going to have

problems with that.

If we're looking at leveling things up so that we're getting more people into our programs, that is something we really want to work with you on, and we think there are ways to do that.

We also think there are ways, short of doing massive consolidation, to bring food stamp eligibility, for example, in under Medi-Cal.

So we'd love to talk to you more about that, and my time is up. Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Kevin.

PANEL MEMBER ASLANIAN: Kevin Aslanian, Coalition of California Welfare Rights Organizations.

I'm going to defer all the praising because that's going to take up my time.

The first issue I want to address is the transformation of the eligibility process. We believe that State administration's the most effective and efficient way of serving our clients. And the thought, the idea that the Medi-Cal Program is so complex, and there's all these complexities, and we should wait to fix those and then go forward, doesn't make sense. Because there's a whole bunch of other states who are doing state administration, and California could also do the same thing.

We also suggest that while you do State administration there should be a local state office, just like they have local Social Security offices, nationwide, that run local programs. I mean, there could be a local state office, I mean to run the office, and the State could also contract with nonprofit organizations to provide services.

Right now, the county has a monopoly as a service provider and we want to break down that monopoly and give the customers a choice as to who they want to go and get the services from. That could be a State office, the county office, the Salvation Army, their church, or their legal service provider. People should have choices.

We also believe that General Assistance should have been encumbered in this program, because General Assistance is an eligibility program so, therefore, they should be part of that.

We support the comments made by Sam Karp regarding this eligibility, the transformation of the eligibility statewide system.

Regarding the $50 disregard. I remember a person who called me the other day, he was complaining that his wife was committing welfare fraud. And the reason he thought his wife was committing welfare fraud is because he was paying $600 child support every month and she didn't

have -- and she couldn't house the kids, she couldn't clothe the kids right to go to school, and he could not understanding what was happening to the $600, after he paid taxes that funded the CalWORKS Program, that his wife got the welfare check, now he's paying another $600 and his wife is at the same level still. The kids are not being housed and fed right.

And of course, I explained to him that his wife only gets $671 a month for a family of three. That's what similarly situated people got in 1989. So his wife was not committing fraud. What was happening was all the child support, except for $50 was going to the State. He was being double taxed.

I suggest, that rather than double taxing these people, what you should basically do is half of the child support should go to the kid. Child support should benefit the children and not the government.

And these are taxpayers, they're already paying us, so they're being double taxed.

Regarding the Medi-Cal fraud targeting. One idea that we had, if I get a service from a Medi-Cal doctor, and we know fraud is pretty rampant in that, what you could do, before the State pays the bill, they can send me a bill saying this is what we're going to pay the doctor.

And if I see something over there that is fishy,

and I inform them, and then they find out that I was right, and they don't pay that, I could get a bonus, like the False Claims Act, of 20 percent. So, therefore, you would have an incentive to sort of policing or monitoring what the doctors do.

One of the biggest reasons why we are here is because this whole theory or idea that there's a partnership between the State and the counties.

In fact, Terri Parker said, we don't want to have a dictatorship versus partnership. It's not a dictatorship versus partnership. The Solano County Supervisor said that the county is the agent, the State is the principal. And the State needs to act like the principal, not like a wimp. It is a known fact that the State acts like a wimp.

In fact, the State is fined with millions and millions of dollars because the counties have 19 computer systems. It's in your report. Why do they have 19 computer systems? Because of county administration. Because they're partners. We don't want to upset our partners so, therefore, let them have LEDER, or MEDER, or CEDER, or whatever they have.

But the other thing, the other point we want to make is that for the work programs, for some reason Welfare-To-Work recipients have been excluded from the regular stream of where people in California would get employment

services.

And when you have a brain tumor, you don't go see a lawyer, you go see a doctor. If you have an employment problem, you should go see an employment counselor, and not a welfare worker.

In California, welfare workers do a great job of eligibility determination. For example, in May of 2004, they were able to sanction, 56,858 participants were sanctioned, in that their benefits were reduced, while they only found jobs for 5,149 people. So it should go to EED. Sorry about the time.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. Kevin, just for the record, your organization is the Coalition of California Welfare Rights Organizations?

PANEL MEMBER ASLANIAN: That's correct.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

Peter Mendoza.

PANEL MEMBER MENDOZA: Madam Chair, Commissioners, for the record my name is Peter Mendoza, and I'd like to first of all thank you for letting me come and speak before you on behalf of the State Council on Developmental Disabilities, and people with developmental disabilities and their families.

The California State Council on Developmental Disabilities is an independent State agency established and

funded by both State and federal laws. The Governor appoints all 29 members, who include consumers with developmental disabilities, members and directors of key State departments and organizations.

The Council's vision is that Californians with disabilities are guaranteed full and equal opportunities for life, liberty, and the pursuit of happiness, as are all Americans.

The Council collaborates, advocates, and promotes, and implements policies and practices that achieve self-determination, independence, productivity, and inclusion in all aspects of community life.

The Council supports the Administration's focus on providing outstanding services to Californians through streamlining government and maximizing the recovery of federal funds.

We commend the Administration for successfully negotiating with the feds to save the IHS Residual Program, by recovering more of federal funding through the waiver.

I understand the need for restructuring to also achieve cost savings where appropriate.

The Council will take official action on the CPR proposals at our September meeting, and will submit additional comments and recommendations by the appropriate deadline.

The Council has long supported simplifying the California delivery system and services in support for consumers with disabilities and their family in a manner that expands successful service models, such as self-determination, and truly enables consumers to be the primary decision makers in their own lives.

This restructuring has the potential of achieving the simplification and creating a more user-friendly method by delivering services and support for consumers and families in a manner that fully includes them in their communities.

I urge a seamless transition in any method of service delivery that includes no interruption in due process rights.

I urge adding an ombudsman type entity, anti-government, that is responsible for customer services, to assist individuals who experience any difficulty in negotiating this new system. And I suggest that that entity be responsible for recognizing and gathering data on, and reporting any special circumstances that will result from the restructured Health and Human Services Department.

I also urge establishing a method to correct any unintended consequences in a timely manner, as soon as possible when they occur.

In closing, I congratulate the Administration for

including, for the first time, individuals with developmental disabilities in the decision process at this high level. And I offer the Council's expertise in assisting the Administration in fulfilling their sincere desire for positive systemic change that will affect, that will make life better for all Californians.

Thank you for your time.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

(Applause.)

COMMISSION CO-CHAIRPERSON KOZBERG: We're now going to turn to the Commission members for their questions.

Dale Bonner.

COMMISSIONER BONNER: This is a question for Catherine, is it Teare, I believe. I think you made a comment to the effect that you can't change the eligibility business processes without changing the underlying requirements, or something to that effect. And it wasn't clear to me whether you were suggesting that by changing the business processes you're necessarily changing the underlying requirements, or whether you were suggesting that one ought not change one without changing the other.

So if you could, one, clarify what you meant, but also give maybe a specific example or two of the interplay.

PANEL MEMBER TEARE: Sure, let me clarify, and I apologize for not being more clear the first time around.

It's not that one cannot, and certainly we see a number of innovations across the State, with Health-e-App, and the One-e-App pilots, and other attempts. The CHDP Gateway is another. Other uses of technology that are improving the system, with the underlying system remaining as it is.

I think there is a limit to how far technological changes can take us in the current complex structure. And so as other speakers have said, I am advocating that we look at this as a whole, and look at the same time at simplifying the underlying eligibility requirements for Medi-Cal and other programs, at the same time as we try to maximize our use of new technologies in order to make enrollment and eligibility process, and beyond just enrollment, actually retention in these programs as seamless, easy, and accessible for families as possible.

COMMISSIONER BONNER: So you're agreeing that you could improve the current business processes, even if there were no underlying changes to the underlying requirements?

PANEL MEMBER TEARE: I think you can. Yeah, and I'm further saying that we should, in order to get, really, the most bang for the buck, look at these things in concert.

COMMISSIONER BONNER: Thank you.

COMMISSION CO-CHAIRPERSON KOZBERG: I have the following Commissioners that wish to ask questions; Jim Canales, Peter Taylor, Russ Gould.

Jim Canales.

COMMISSIONER CANALES: Great, thank you, Madam Chairwoman.

A couple, one observation and then one question. The observation is I just wanted to commend Mr. Herald and his colleagues for making the important point about ensuring that as we think about consolidating eligibility requirements that we not level down and, in essence, end up in a reduction of services.

And I just want to tie that back to the presentation made by the CPR Team Leaders, earlier today, where they made the very important point that the cost savings that they had identified were cost savings that would not result in a reduction of services.

So it seems to me that given that principle as really one of the underlying tenets, that indeed the concern that you raised is one that, hopefully, is very much on the radar screen and one we will be attentive to.

My question is really, I think, for Ms. Ward and Ms. Teare, because you alluded to it in your written testimony, but I don't think either of you had time to address it, and it relates to Recommendation 28 and the use of Smart Cards.

And obviously, on its face, for those of us who are perhaps not as educated as you are about this subject,

it appears to be a very sensible option, to think about automating and using technology in a way that will help to reduce fraud and also simplify the process.

But I would be interested to have you each comment on what your concerns are about the use of Smart Card technology, because in your testimony you alluded to that. Thank you.

PANEL MEMBER WARD: Okay, I'll take a shot at that. I think what we're hearing from our constituents is that Smart Cards and the technology requiring fingerprinting raises a lot of concerns, particularly with the elderly and children, sometimes fingerprints cannot be validated.

For immigrant communities, where adults would have to verify and be the person that would be fingerprinted, we feel might get at their privacy issues and would deter them from accessing care if they have to be fingerprinted.

We've seen this in other cases, where people have had to be fingerprinted, and just avoid taking their kids to the doctor, altogether. So that's one of our primary concerns.

And then the whole idea of having personal information available and its impact on HIPAA, and some of the information accountability requirements, as well.

PANEL MEMBER TEARE: Those are essentially the same reasons that I raise in my objection to this

recommendation. Very specifically, for children, whose fingerprints are not stable and can't be used, it really doesn't -- it is not always a parent who takes a child to the doctor, there are many other caregivers, grandparents, and others. And so just in that very simple, practical way, there's a barrier to care that arises from the use of Smart Cards.

I'm also not convinced, although not expert in this area, there is much evidence of significant drop in fraud as a result, and I would question further whether the cost benefit weighs out in this case.

COMMISSION CO-CHAIRPERSON KOZBERG: Peter Taylor.

PANEL MEMBER WARD: If I could just add, quickly. I think another issue for our clinics is that they're currently under a lot of different anti-fraud requirements, and we just think that we need to continue to look at other approaches versus moving to such an invasive process.

COMMISSION CO-CHAIRPERSON KOZBERG: Peter.

COMMISSIONER TAYLOR: A question for Ms. Holle, is it, Marilyn?

PANEL MEMBER HOLLE: Yes.

COMMISSIONER TAYLOR: You had mentioned you were opposed to the idea of transferring the IHSS Program to the Department of Health Services. I want to dig down for a second on the reasons for that.

PANEL MEMBER HOLLE: Yes.

COMMISSIONER TAYLOR: Because in the materials that the CPR workgroup shared with us, they had some pretty compelling numbers about the opportunity to increase federal reimbursements that would come with the transfer, as well as avoiding certain costs. They reference $195 million in the current year budget to pay for the cost and delays in reimbursements.

Is your objection because you disagree with that analysis and those numbers, you don't think, are particularly online, or is it an issue of you think transferring the program will result in less appropriate care for patients?

PANEL MEMBER HOLLE: There's no reason why keeping it at DSS, as opposed to DHS, would affect in any way federal reimbursement. Just as transferring, to the Department of Mental Health, oversight responsibilities with respect to the county mental health plans, that has no impact. There's really no basis for that.

The reason for the opposition is the history of the program and the real importance that it not be medicalized, that it retain its cost-effective, social model character.

I see nothing in the report that provides a basis that there's a financial cost, and I'm not certain what it

would be. Because I've worked with this program since 1978, through lots of its transformations, and I see nothing that affects the federal reimbursement that relates to whether it's at DSS or DHS. And I just see the problems.

You know, one of our experiences is to allow people on nursing facility waivers to, instead of using expensive nurses, to have access to additional attentive care, personal care service hours.

That was enacted by a bill, sponsored by ADAPT. It took a couple years to get it started. It got started, you know, without any sensitivity or understanding of the nature of the program, and where it's got some improvements, but we still haven't gotten it implemented in the way it needs to be implemented to really allow people the more cost effective access to waiver of personal care services versus State plan authorized personal care services.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you. Russ Gould, then Patricia Bates. Steve Olsen and J.J.

COMMISSIONER GOULD: First, I'd like to thank Lucien for mentioning Steve Thompson. He was both a very good friend, a great advocate, and I'm sure we'd like nothing better than to have his forceful counsel here today.

(Applause.)

COMMISSIONER GOULD: Marilyn, if I could return to something you mentioned earlier, it would be helpful.

PANEL MEMBER HOLLE: Sure.

COMMISSIONER GOULD: You mentioned there are individuals who are going to have difficulty navigating the internet on an eligibility transformation. What kind of models have you seen, or support? We've talked about community-based organizations providing assistance there. What other approaches are there to ensure that people do have appropriate access?

PANEL MEMBER HOLLE: I think, for instance, I know for people with psychiatric disabilities, some of the self-help centers have computer access and assist people with computer access.

I've seen really good results from programs sponsored through public libraries.

I think there is a strong desire for people to use the internet in an increased way, and I think it's just incumbent upon people to provide assistance in getting to the places where they can both get the services and get the hands-on assistance about stepping through the process. Mindful, of course, of all the complexities of the privacy issues.

COMMISSION CO-CHAIRPERSON KOZBERG: Patricia.

COMMISSIONER DANDO: Thank you, for Ms. Teare, you raised the issue of the reduction in reimbursement for providers in the licensed-exempt category for childcare.

And this is a real concern of mine and certainly support your concerns.

This has been a problem in Medi-Cal, clearly. So what do you see or know that might be available in our community, currently, that could take up that gap? You've suggested it should be an assessment. What do we need to look at before we take that step in terms of recruiting providers, training providers? I see that as a huge cost issue that might be of importance here, as we're looking at cost cutting, are we adding some in on the other side of the equation?

How would you want to approach that in terms of recommendations to this Commission? We need, I think, more specific steps.

PANEL MEMBER TEARE: Well, I think it is a very complicated issue. This is an issue that I think many of you, and others in the room, have been dealing with for a long time. And I know there are people here, who will speak during the public comment, who can also address this from the provider side.

I do think that this is an area where we need to avoid piecemeal approaches and look at the system in its totality. Given movement toward other early care and education issues, such as preschool for all kids, I think there's a whole shift in how we're delivering early care and

education and we need to look very carefully.

That said, specific to licensed-exempt providers and their reimbursement rate, our feeling is very clear that there should be reimbursement that varies, depending upon the qualifications of the provider, and that clearly it is in the interest of California's children for providers to have training, et cetera.

However, we can't achieve that by punishing providers who have been in the system, who are caring for kids who may not have access to other providers of higher quality, as sort of a bold way to put it.

And so we need to figure out how to support providers who choose to move in, but also recognize that many license-exempt providers are not seeking to make a career out of childcare, and are helping out their families in a way that the State has allowed as part of encouraging families to go to work.

COMMISSION CO-CHAIRPERSON KOZBERG: Steve.

COMMISSIONER OLSEN: My question's for Lucien Wulsin. Lucien, I'm a little rusty on my healthcare finance, so you're going to have to help me out here. But you've made reference to the 1115 waiver process is an opportunity the State should be exploring.

And I would guess that had federal matching funds for uninsured childless adults been available, we would have

taken advantage of it a long time ago. So I guess the question is what's the catch?

There are some references here to budgetary caps, or perhaps some interactions with 855 or 1255 funds. What are we really getting into if we go after a waiver of this sort?

PANEL MEMBER WULSIN: I think we're getting into a long, protracted negotiation which could be very beneficial to California if it results in a good waiver. And if it results in a bad waiver, then we simply say we're not interested.

Let me take you through what the issues are, as I see them. In order to get federal financing for adults, you do have to ask for an 1115 waiver, and an 1115 waiver is subject to a budgetary cap.

How you compute that cap varies depending upon the Administration and its willingness to negotiate with that particular state. Some states have gotten very favorable caps and very favorable growth rates.

And you have to do that in California to make this work because we are already, as you've probably earlier noted, one of the lowest in the country in terms of our spending per eligible, so we don't have a lot of room.

The second thing you have to do is you have to come up with a set of things that you're prepared to give

up, and you have to negotiate those with the federal government, and it has to be consistent, to some degree, with what the Federal Administration and the power is willing to go for.

Obviously, one of the issues in Medi-Cal redesign, about which there is a great deal of disagreement, both among advocates, providers, and plans, and everyone else, is the issue of expansion of managed care to other populations, beyond those that exist now. That's one issue.

The other issue that I kind of highlighted earlier, is that if you do compensate people for care, there is a cap that applies to each individual hospital, known by the alphabet soup of the "Over Dish Cap" and it's specific to each hospital. And so if you're moving from uncompensated care to compensated care, there's some impacts.

So those are the sorts of things that you have to negotiate as part of the waiver. It's not a quick, slam dunk thing. But Arizona led the way back in the eighties. Oregon did so in the early nineties. And New York and Massachusetts were more recent, and Tennessee was kind of interim.

It's a possible step. We spend about $1.8 billion at the county level, so there is a lot of money that's available, if we can secure and negotiate that on favorable

terms to California.

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

J.J., and then the last question will then belong to David Davenport.

COMMISSIONER JELINCIC: This is actually for any of the Panel Members. As Senator Brulte pointed out in last week, which I guess was in Riverside, if we simply move costs from one governmental agency or level of government to another, we really haven't done much.

There's a proposal, and I want to go back to the in-home support services, to move that from the counties to the State. And I'm wondering what people see as how that would either cut net costs or improve the quality of service as we have made, what's essentially a local issue at this point, a State issue?

PANEL MEMBER HOLLE: In terms of right now, if somebody is not authorized the hours needed to stay at home, what often happens to grandma is grandma goes into long-term care. When grandma goes from her own home to long-term care, the county is off the hook financially.

So it's my understanding that the notion of to bring IHSS under the State, it's to be able to sort of look at long-term care costs globally, and try to work toward cost effectiveness.

I think that makes sense. And I don't see any way

to shift risk back to the county. So the State's at risk for long-term care, and so it makes sense that the State, with that sort of global responsibility, have the financial responsibility, and include that along with adult day healthcare and other services that look to ways of delivering cost-effective services to avoid the more costly out-of-home placements.

PANEL MEMBER ASLANIAN: In addition, when you have 58 different counties running the system, that means you have 58 different policies. And if you have 58 different people more writing different policies, because each county has their own manual, their own memos, their own policies.

Whereas, if it's statewide, you only have maybe ten people writing one manual, and policies that applies to all counties.

So that's how you have a lot of savings from State administration of not only IHSS, but Medi-Cal, food stamps, and the rest of the host of the programs.

PANEL MEMBER HOLLE: I really want to say that the current trailer bill provides some pretty significant quality assurance initiatives to try to bring greater uniformity and accountability in the system, and we may want to look to see how that all plays out.

It's a quality assurance initiative being undertaken in conjunction with the waiver that was just

negotiated to bring down a federal match for those parts of the IHSS program that currently do not receive federal match.

PANEL MEMBER MENDOZA: I think one of the things that's important, too, if you don't mind me just jumping in, is that when you move, if you're on IHSS and you move from one county to the other, there has to be another reassessment. Okay, which means it costs more money to have a social worker who comes out and reassesses you, and in some cases you have to have a public nurse come out.

And if we can only have a person reassessed once, and if you move from one place to another it's usually no big deal, you don't need to be reassessed. So that would be a significant cost savings because a lot of people do move in this State.

It would also ensure that their hours stay the same. Because if you're assessed by one entity, and you go to a different county, they'll keep the same hours.

In some counties you can lose some hours or gain some hours depending on the situation. So you want to keep everything consistent.

Additionally, speaking as an individual, I would hope if we go through this process we could really move programs like this to a social model, rather than a medical model. Because a person who has a severe disability, like

myself, I have Cerebral Palsy, really doesn't need to be reassessed every year. I'm disabled, I'm going to be disabled until the day I pass away.

So make that assessment less for people with severe disabilities. And maybe, for people that have disabilities that may change, you know maintain the assessment level.

But what happens in some cases is that the worker comes out and they go, you're still disabled, you still have the same needs, and they're required to spend about 45 minutes with you and then they leave, and you talk about everything, including their children. Which is great, but really doesn't save the State money.

(Laughter.)

COMMISSION CO-CHAIRPERSON KOZBERG: Thank you.

COMMISSIONER DAVENPORT: There's one sort of big question on which I imagine we're making an assumption, and I just want to give you a chance to comment on it, if we're incorrect. And that is the report seems to assume that creating a more powerful Secretary of Health and Human Services, with a half a dozen undersecretaries, consolidating some things that have been placed elsewhere, will in general improve, both organizationally and from the point of view of advocacy, I assume, the situation in this whole Health and Human Services area.

Is there general agreement with that, or are there people who have reservations about that, or do you feel that's just a neutral organizational step, the creation of the more powerful Secretary?

PANEL MEMBER HOLLE: We, at Protection and Advocacy don't know. We know there's certain advantages to smaller entities, like the Major Risk Medical Insurance Board being, I think, a model State agency in terms of efficiency and ability to get out regulations. We don't know what the result is going to be. We have no idea.

We've looked at it, thought about it, and really don't feel equipped to come up with a solution because sometimes bigger is not better.

COMMISSIONER JELINCIC: I think it depends on who the Secretary is, too.

COMMISSION CO-CHAIRPERSON KOZBERG: Mike.

PANEL MEMBER HERALD: I agree, it's very difficult to determine the impact. However, it seems that a concentration of policymaking power in the Secretary's hands could have the affect of lessening the sophistication of our analysis and work. Because the more we get away from the experienced and knowledgeable workers, who are in State agencies, and at the county level, also, I think the more the product might tend to get homogenized and we might miss important details.

I think the other issue for us is the issue around accessibility and transparency of the decision-making process. The reality is that Secretaries are very hard to access for the public, even those of us who are professionals and do this all the time. You know, we love meeting with Secretary Belshe, but it's not going to happen every day.

Department heads are a little easier to access. But to the degree to which they don't have policy-making power, that access becomes significantly less important.

So I think there are real questions about this model and we would certainly be interested in the conversation, but I don't know that we're sold that this is the correct way to go at this point.

COMMISSION CO-CHAIRPERSON KOZBERG: I'd like to thank the Panel for your very significant contribution to this process.

(Applause.)

COMMISSION CO-CHAIRPERSON KOZBERG: The next Panel is the Service Providers Panel.

I'd like to also introduce the audience to the Co-Chair of the Commission, Bill Hauck.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Joanne.

Steve Escoboza. You all know who you are.

Elia Gallardo. Bob Hertzka and Steve Tough.

Okay, are you all ready? Let's start with Steve.

PANEL MEMBER ESCOBOZA: Good afternoon, Members of the Commission. I'm Steve Escoboza, President and CEO of the Healthcare Association of San Diego and Imperial Counties, although today I'm here on behalf of the California Healthcare Association, and its 500 plus members.

CHA, the California Healthcare Association, is very supportive of the CPR process and many of the recommendations and proposals within that report.

However, there are some recommendations that we believe require some further development, as well as input from all stakeholders, a part of the healthcare system in the State.

I'd like to highlight and comment on four specific recommendations in the report, very briefly, and then talk to a couple of proposals that are referenced within the deeper report, relative to organizational improvements.

The first recommendation that I'd like to speak to is HHS 02, which refers to the realignment. Realignment will only be successful if there is adequate funding for these services, regardless of where those services are provided, whether it be at the State or at the county level.

We support federalizing the Medically Indigent Adults Program by including it in Medi-Cal in order to

obtain FFP. However, we believe a broad-based workgroup should be formed to study this issue much more thoroughly.

The second recommendation that I would speak to is HHS 29, wherein the report talks about redirecting Medi-Cal/hospital disproportionate share of payments.

Of course, you would imagine that this proposal causes us some concern. Acute care hospitals that provide essential health services to large volumes of Medi-Cal, and uninsured patients, as you know, are the cornerstone of the safety net system in this State.

The elimination or reduction of DSH funding to existing safety net hospitals would threaten, of course, their fiscal viability and could result in potential hospital closures or services reductions.

Great care must be taken in upsetting that delicate balance in DSH funding, and particularly in tying that funding, as is proposed, to measures, such as Seismic Safety Law, and limiting it just to certain core services.

HHS 30, Centralized Medi-Cal Treatment Authorization Process. We don't believe that this recommendation will fix the broken TAR process. Medi-Cal should consider efforts to reduce fraud and utilization review used both by Medicare and commercial health plans, and use similar tools, rather than merely modify the current, ineffective system of TARs.

And we have provided you, in written testimony, recommendations to that effect.

HHS 31, Medical Fraud. While we obviously support the recommendation to reduce fraud, this should be implemented in a manner that does not result in additional administrative burdens to those legitimate providers who already receive the lowest reimbursement rates in the nation. Additional hoops could result in fewer participating providers, shifting primary care to more costly hospital emergency rooms.

The two areas that are not specific, but in the report, deal with transferring functions of the Department of Managed Healthcare to Health and Human Services, and then the change in the California Medical Assistance Proposal.

Actually, the nature of both proposals and the transfer or those proposals, or elimination of those services is pretty unclear to us at this time.

It is very important, we believe, that the Department of Managed Care be retained intact as a consolidated effort of managed care, regardless of whether it gets transferred to a super-department. Those functions are very important in regulating managed care plans, and not an easy function to manage, as it is, but to not keep it intact could be a problem.

And clearly, the proposal to eliminate CMAC is

unclear. We believe, though, that it's very critical that the negotiator of rates not also be the payer of rates.

Thank you.

COMMISSION CO-CHAIRPERSON HAUCK: You're next.

PANEL MEMBER GALLARDO: Elia Gallardo, with the California Primary Care Association, or CPCA.

CPCA is a recognized leader and recognized voice of California's community clinics and health centers, and their patients.

CPCA represents over 600 nonprofit clinics that provide comprehensive, quality healthcare services to low income, uninsured, and under-served Californians who might otherwise go without care.

First, on behalf of our membership, I'd like to join the many voices in thanking the more than 250 State employees, the California Performance Review Staff, and the Commissioners for their thoughtful and thought provoking recommendations outlined in the CPR.

The CPR was released at a time when the healthcare community was anticipating another major proposal, the Medicaid redesign, and I know that that was mentioned in the previous panel. In our comments to the Administration, we actually urge them to take very much a similar approach as that that was taken by the CPR, focusing on administrative simplification, the elimination of bureaucratic barriers,

and enhancement of consumer oriented services.

As the CPR highlights, hundreds of millions of dollars in healthcare funding can be saved in streamlining efforts that support Medi-Cal beneficiaries and beneficiaries of other healthcare programs. We strongly urge, in looking at that proposal, that the Administration again follow and look at those proposals that are forwarded by the CPR.

I'm going to try to focus in on a few of the proposals that relate to healthcare services, the first one on the consolidation of licensure and certification processes.

We strongly share the CPR's commitment to the administrative efficiencies. Consolidation of licensing and certification should improve State services by reducing unnecessary administrative burdens and improving coordination.

One of the potential efficiencies noted by the CPR includes the improvement of common professional skills set for staff. While the development of the standardized skill set should improve the licensing and credentialing of providers, it's imperative that the consolidation proposal also ensure that surveyors are adequately trained regarding the specific statutory and regulatory provisions governing specific facilities.

Currently, primary care clinics confront LNC, licensing and certification surveyors that apply inapplicable requirements, apply underground regulations, and fail to enforce existing statutes.

Further streamlining in the area of licensure and certification process, for many of the government-sponsored healthcare programs, should be explored. For example, community clinics and health centers must already complete an arduous licensing process before they can provide healthcare services. The end of that licensing process is the issuance of a Medi-Cal provider number. After being issued the Medi-Cal provider number, a clinic must fill out separate applications for each of the other government run healthcare programs.

The additional programs often ask for the same information that was required under the initial process, leading to unnecessary and costly administrative duplication. Permitting primary care clinics and other similarly situated providers to enroll in Medi-Cal and other public health programs during the extensive Medi-Cal licensure and certification process would reduce unnecessary administrative costs for clinics and the State.

I have to, at this point, acknowledge Senator Ducheny, and her efforts in this area, to assist us in streamlining some of these processes.

The CPR also talks about the E-TAR statewide implementation. According to a 2003 Medi-Cal Policy Institute Report on the TAR process, Medi-Cal patients have been put at risk by preauthorization delays, which forced providers to delay necessary care. If the providers do provide this service, which most of them do, then they're put at financial risk because they must wait for the authorization and receive payment for the services rendered retroactively.

Statewide implementation of the E-TAR system should reduce processing time and we're extremely supportive of that effort. The Medi-Cal Policy Institute Report does discuss how most organizations that process authorization requests for services use the National Committee on Quality Assurance standard of two days' turnaround.

In 2003, processing time for Medi-Cal TARS averaged between 9 and 12 working days. So we'd strongly support the use of the E-TAR process.

I am out of time really quickly, so I refer you to the other comments that we have. We are looking at the other health coverage in the Medi-Cal system, where we're concerned how the Medi-Cal beneficiaries will be able to receive their full entitlement of services. If they do have other health coverage, they currently face some difficulties in ensuring that they have that full scope of service. We

want to make sure that those issues are addressed in that proposal.

With realignment, we're concerned with some of the county programs, that actually do a wonderful job and provide comprehensive care to medically indigent adults, and some of the infrastructure that was set up to ensure that those services are provided, we want to make sure that the State carefully looks at that infrastructure and assures that that community-based level of service delivery isn't destabilized.

And the Smart Cards were addressed in the previous panel, so I'll stop there. Thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you.

Bob.

PANEL MEMBER HERTZKA: Right. Good, okay. Well, thanks.

First, maybe even outside of my five minutes, I'd like to acknowledge all of the --

COMMISSION CO-CHAIRPERSON HAUCK: Say who you are and the organization?

PANEL MEMBER HERTZKA: Oh, I'm sorry. Bob Hertzka, President of the California Medical Association.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you.

PANEL MEMBER HERTZKA: And I'd just like to, just

as a point of personal privilege, just thank all the folks, including the Panelists, who've had such wonderful things to say about Steve Thompson. Many of you, I suspect, will be joining me tomorrow morning at his service up in Sacramento. And for whatever it's worth, I think helping to prepare me for this testimony may have been the last thing that Steve actually worked on with us at the CMA. So thank you for all of the kind thoughts that the Medical Association's been receiving on his behalf. Words can't begin to describe our loss. Thank you.

On a personal note, I want to thank the Panel and the Commission here for all the work that they've done, and for the stamina and the interest that you've shown today. You're here at my Medical School Alma Mater. But when I went here, we bought our books in bungalows. They've certainly upgraded the facilities since I was a student.

To the points. The one recommendation I'd like to highlight, that we are extremely fond of, and would like you to encourage following this all the way through, is to create a separate position of State Public Health Officer. And as the Little Hoover Commission recommended, breaking public health away from the vastness of DHS.

Now, we'd encourage you, and those that you work with to follow through and find, and adequately compensate an appropriately trained physician to take charge and give

California the kind of physician leadership that other states have enjoyed in terms of management of critical public health issues.

In some areas that we'd like to otherwise comment about, a main issue of interest to us is Department of Managed Healthcare, their recommendations to move it inside DHHS, and all that, and the moving the boxes around stuff we can talk about at any point in time.

What we want to raise at this point is that we actually think that the Department of Managed Healthcare hasn't really been hitting the mark all along, and the CMA, even a couple years ago, internally voted that we would seek, even in the last Administration, just maybe even replacing it entirely. Because we felt that if you look at some of the fundamental issues that brought the DMHC into existence, we don't think they've necessarily been addressed.

Managed healthcare and health insurance products, in general, are very complicated issues that involve solvency, solvency of the entity, solvency of the medical groups they're being contracted with, and appropriate dealings with physician providers in terms of prompt and adequate payment, and all sorts of things, and things that we continue to struggle with as recently as the floor of the State Legislature yesterday.

So we would like to put forth the recommendation that regulation of health plans fall in a separate, stand-alone entity, and an entity that not only is looking at healthcare quality, but also has the appropriate financial expertise and the ability to enforce. And we would put that recommendation forth.

Secondly, of major concern to us, second of the two major, major areas, would be dealing with the Medical Board of California, from a couple of different aspects. Putting the Medical Board into the Department of Health Services, per se, again moving the boxes around, we don't have a real opinion about that. But the concept of eliminating the actual Medical Board of California, I would submit that the citizens of California benefit from having a panel, the majority of whom are actually practicing physicians, providing oversight and input into a critical State need, which is maintaining the quality of physician care. And I would note that that entity is self-funded by physician fees and so it's not a State burden.

And then the other area within the Medical Board areas is the concept of enforcement, which is being proposed to be forwarded over to the delightful Department of Homeland Security. And I'll just say, for the record, the Medical Association would much rather have our enforcement and our investigation handled by nurses, with two weeks of

cop training, than what we have now, which is cops with two weeks of medical training.

There's a reference here that Homeland Security folks are sworn peace officers who carry guns. The Medical Association says, please, take away the guns. We can get appropriately trained people, and it can be a much better process, and probably save money. So that's my sound bite here for the day.

Other minor points within my five minutes, important, but less dramatic for us, hospital licensure is something that in fact just recently, a couple of days, we were dealing with, is a very delicate and important area. And this State, and this State alone has had what's called Title 22, which has given physicians particular direct input into looking into the quality of care in hospitals, expertise that only practicing physicians can provide, and we would hope that whatever solution comes out of hospital licensure would maintain a strong, particularly strong role for physicians in the State.

We're concerned about rolling Emergency Management Services again into the aforementioned Department of Homeland Security. We see a big difference between the rank and file Californian having chest pain or being hit by a car, versus terrorism, disasters, and things like that. And we're very concerned that if you bury the day-to-day

concerns of someone with chest pain in a big bureaucracy that's more interested in Bin Laden, we think things will be lost.

Oh, I thought I had a one-minute warning. Wow, this just goes fast.

Last comment would be then, Smart Cards, we heard a lot about them. Fraud is a big concern. We want you to think big, we want you to think of the world where I walk into an emergency room in San Diego, and my Smart Card enables me to hook into an infrastructure so they know I was in an emergency room in Los Angeles six weeks ago. That's what we should be thinking about.

If we're going to get into this kind of technology, let's do it in a way that, sure, stop the fraud, but let's use this as an opportunity to enhance patient care. Thank you very much.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Steve.

PANEL MEMBER TOUGH: Thank you, Bill.

My name's Steve Tough, I'm the President and CEO of the California Association of Health Plans, and I appreciate the opportunity to address the Commission today.

Given the need to preserve time, I'll try to move as quickly as possible. I'll avoid all the niceties about

the Association, just indicate that we, as background, represent 31 full service health plans and we operate here, in California, representing 22 million members across the State.

From a general comment standpoint, certainly support and applaud the State of California's goals in improving the way it operates and provides services for the residents of California.

We support the State's effort to expand the use of technology and automation in an effort to improve efficiency and reduce costs.

We are pleased that the CPR report included a recommendation to streamline the audit functions at health plans, as considerable resources are being spent to respond to multiple audits by various governmental agencies and private accreditation organizations.

This improvement, alone, will have tremendous value to permit the use of precious healthcare resources to be focused on targeted oversight rather than duplicative processes and checklists.

We also believe that any change in the State's healthcare programs must be focused on expanding access to healthcare services for California's population. We are well aware of the high and growing numbers of uninsured across the State, and we believe that creating greater

access to healthcare and healthcare coverage should be the primary motivating factor in any change.

With that in mind, we strongly support the State's recommendation to reinstate the $50 incentive fee for providing assistance and enrolling people in the State's Healthy Families Programs, and implementing a similar fee for the combined application for Medi-Cal, Cal-WORKS, and Food Stamps.

A similar fee program was discontinued last year, and we've seen a decline in the Healthy Families enrollment this last year, which precludes the State from maximizing the federal funds available for this program.

The incentive fee program, promoted through grass roots and community-based organizations can be an important step in increasing access for children, the most important and most vulnerable of our population.

We also support the concept of moving to a One-e-App for various programs that share eligibility requirements. By allowing enrollment into multiple programs, with one application, the State can save time and money, and eliminate needless duplication and processing of eligibility and enrollment.

We're concerned about the implications of the potential funding deficiencies that might occur with the elimination or blending of payments to the State's dual

eligibles, the Medicare, Medi-Cal population, where those eligibles are enrolled for both Federal Medicare and State Medi-Cal coverage.

Often, these dual eligibles have unique healthcare issues and needs that warrant higher payment structure to ensure that they maintain access to the necessary healthcare services. This is a high risk population that requires much more healthcare services than the average population and the current payment rates for both Medi-Cal and Medicare are already low, and payment reductions for this combined population could be problematic in the future.

As for the recommendations affecting the Department of Managed Health Care, we understand and appreciate the State's desire to streamline its organizational structure and reduce duplication.

However, it's not yet clear as to whether DMHC will be moved in whole or under the DHHS Center for Quality Assurance, or whether the various functions of DMHC will be spread out through various departments across the State structure.

Functions, such as licensing, rule making, enforcement, and complaint resolution are integrated and co-dependent in many ways.

We're concerned that the consolidation of these functions for simplification could potentially lead to

reduced efficiency due to governmental oversight that is less responsible, resulting in a massive coordination across a large agency.

We're also concerned about how the regulatory oversight product development and licensure will take place during a transition.

Our member health plans are routinely creating new products, making adjustments to plans, making changes to existing plan structures in order to meet the demands of our consumers in the marketplace.

We must ensure that the licensing of these new products not be halted or delayed during the creation, development, and the implementation of the new oversight entity.

While the DMHC is still relatively young in age, in contrast, perhaps, to Bob's earlier comments, we feel they've made significant strides. All have worked together to develop processes that are currently working well.

For the industry, the DMHC has provided a single point of entry that has evolved to be both functional and accountable.

We only ask that any changes contemplated ensure that the advances that have been made, and the processes, which are now working smoothly for consumers, not get lost in the translation of the final structure.

Thank you, and I appreciate having the opportunity to comment today.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Steve.

Questions? Joel.

COMMISSIONER GOULD: Mr. Chairman, more of a request, but spinning off of a document from Dr. Hertzka on the elimination of the Medical Board of California. We've heard, in our Riverside appearance and here, also, all the Boards that are going to be eliminated, the so-called self-funded boards, and we wondered if we could get some kind of an outline or matrix of all the boards that are to be eliminated, their functions and their funding, and whether there are State subsidies involved, or State employees involved.

Because even beyond the hearings we're having I'm sure, like myself, everyone has been grabbed, walking down a hallway, saying "my board's great and we're self-funded." I'd like to see that all laid out and I wonder if that's possible, Mr. Chairman?

COMMISSION CO-CHAIRPERSON HAUCK: Yeah, I think that's possible. We'll put Andrew to work on it.

Terri?

TEAM LEADER PARKER: Mr. Chairman, I just want to make a point that the -- if I yell loud? The Medical Board

was not proposed for elimination. I don't know if there is a confusion somewhere, because many of the -- some of the licensing and professional boards were moved from the Secretary of Consumer Affairs to the Health and Welfare area. They were moved, they were not eliminated.

There are a few that are proposed for elimination, but that is not one, sir.

PANEL MEMBER HERTZKA: And that was what, again, the 2,500 pages and there are a lot, that what the understanding had been was that at least one of the options was to consolidate physicians with other professionals into a single Health Professionals Board. And so if that's not the case then no problem, then no need to worry about my prior comments.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, but we can still be responsive to that request, Joel. I think that while the statement is probably mostly true in terms of the funding, there's also the issue of the use of the State's police power and licensing.

COMMISSIONER GOULD: Right, the travel and whatever else there is.

COMMISSION CO-CHAIRPERSON HAUCK: Right. Other questions? Denise.

COMMISSIONER DUCHENY: I have a couple and they probably go to different folks, but on the subject of boards

and commissions, since we're there, and maybe Terri's the right person on this first one, but so would the Dental Board move also to the Health and Human Services, because that's under Consumer Services, now, or is that the kind of thing you're talking about? Or is that the kind that Bob's talking about, that maybe you were trying to consolidate them?

TEAM LEADER PARKER: Senator, again, there's a few of them that are listed. I realize, and I'm sorry that Chon's not here, because this is really kind of a Chon answer.

I appreciate your confusion, I think that there is a tremendous amount of confusion about what was proposed for elimination and where things were proposed to be transferred.

I just would say, for the professions that we looked at in the Health and Welfare area, that for the most part we moved them from the Consumer Affairs Agency to Health and Welfare, so that the licensing for the facilities and also the professional providers were in one entity.

There is very few, if any, that were consolidated. And we did recognize that not only do those Boards pay for themselves, but also they really need the professional expertise of those individuals to do their appeals, and hearings, and also set the quality of standards for them.

At least in our particular area we looked at. Had we not done that, we would probably have to pay to have that done.

So with the few exceptions of where there may be boards and commissions in our area that were eliminated, it was in that sense the idea that the Agency Secretary might form them for advocacy and input. But not on the professional boards, for the most part.

COMMISSIONER DUCHENY: Well, I only ask it, and maybe it's the more general stuff, but I do think, I mean there is some logic to perhaps putting nursing, and dental, and some of those in Health, instead of over, off by themselves in the licensing world.

But on the bigger questions, and I know I have testimony that I submitted to Joanne earlier, from the rural health clinics, and others who are very concerned about the Rural Health Council, the Office of Bi-National Health, and some of those advisory panels that kind of might get lost in the shuffle, and I'm looking to all of you kind of on the bigger questions of CMAC and MRMIB, and the big ones, whether there's a sense that all of those are necessary, or could some of their work be consolidated when you get into trying to negotiate the contracts?

And on the DMHC, they sort of blow up the box, there's always a contradiction on that one. I think Corporations is not the place for it, but I think Health is

one option, or Insurance is a different option. And anybody who'd care to comment on that one? You can fight about it, it will be fun.

COMMISSION CO-CHAIRPERSON HAUCK: Anybody want to get into that?

COMMISSIONER DUCHENY: But MRMIB and CMAC, also.

PANEL MEMBER TOUGH: From an Association standpoint, we've had several discussions about the DMHC should be located here or there, and actually there's a whole host, as you might guess, in an Association like ours there's mixed views. Some feel that it could fit nicely and continue to stay nicely in VTNH. Some indicate that it fits nicely in HHS. Some indicate that there may be some logical ties to Insurance. I don't think there's a consistent view and, unfortunately, there's not a lot of detail, enough to get through that in a way that gives you a sense of how it would fall one or another.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, J.J.

COMMISSIONER JELINCIC: Dr. Hertzka, one of the things that I think we did is we asked the wrong question. We asked how to do things more cheaply, rather than ask what we should be doing and what kind of world we want to leave our kids.

But you raised an interesting issue with the E-Cards and putting some of the medical records on that card.

How much of the medical records do you think we ought to do, you know, so it's available for treating physicians, and how widespread should we actually push that kind of technology?

PANEL MEMBER HERTZKA: Well, I don't see a whole lot of limits in terms of things that the individual patient would voluntarily be willing to share. So, for example, I was just briefed within one of the healthcare systems in this County, that has five, six hospitals, you can actually go to emergency rooms 30, 40 miles apart and there are records of those visits so you don't have to repeat chest X-rays.

Or on the less exciting side, if somebody's shopping for Vicodins at multiple facilities, you can pick that up. And so it has good implications all the way around. I think that's fine.

In Seattle, they've got some funding, Microsoft or somebody, and the entire City is wired for that sort of thing. It's most important, really, I think in terms of avoiding duplicative and unnecessary testing, and duplicative and unnecessary prescribing, even well-intended things, if you give somebody something for blood pressure and you don't know that somebody else has done that.

And I think the technology is there. There's some federal privacy protections that have to get worked through. But if the will is there for the quality of care aspects, I

don't think it's that difficult. Frankly, I think there's some value for health plans even making contributions to this kind of effort, and we've had some discussions with the health plan folks because they'd save a ton of money in terms of paying for unnecessary testing.

There are a lot of things. There are actually national foundations and projects looking at it. To the extent that people are interested, our Executive Vice President of our Association, Dr. Jack Lewin is involved nationally on this and is prepared to go anytime, anyplace and lay out all the wonderful possibilities that are there. For yes, an initial State investment. But in the long run you actually save money and boost, the best thing, from our point of view, is you boost healthcare quality.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you. Any other questions? Mr. Bonner.

COMMISSIONER BONNER: Thank you, sir.

COMMISSION CO-CHAIRPERSON HAUCK: You're welcome.

COMMISSIONER BONNER: This is a question for Dr. Hertzka. Could you comment a little more specifically on how, in your view, I think I generally understand some of the policy differences or concerns you have with the DMHC's oversight of the healthplan industry, but can you comment a little more specifically on how that may be influenced, one way or the other, on the structural makeup of the

Department, or where it rests from an organizational standpoint? Or is the structure and organization less relevant?

PANEL MEMBER HERTZKA: Right. Actually, I think from the -- you know we're using this as an opportunity to express some of our ongoing issues.

From a structural point of view I would agree with Mr. Tough that you do want to consolidate these functions. We're even suggesting you consolidate them more, so you aren't differentiating, necessarily, different types of health plans. So that a health insurance, right now, may have to deal with Department of Insurance for some things and the Department of Managed Healthcare for others. We'd actually call for more consolidation and more oversight.

But then what's been left out of the whole DMHC equation is there's clearly been a necessity to regulate health plans, and the health plans have been willing to have appropriate regulation. And then the consumers have tremendous interests, and they vote, and so that clearly gets a lot of people's attention.

And the physicians have often been lost in the middle, because what makes consumers and health plans kind of work, sometimes leaves the physicians either fiscally, or by contract obligation to provide care after an insolvency, things like that. We've been left without a place where we

can appeal and bring our issues.

And so we're envisioning a more global regulatory entity that would consider physicians and healthcare providers an equal partner with those folks who do the financial health plan part and then, of course, the consumers and the patient.

And so that is probably beyond, arguably beyond the purview of what you would recommend. We have no objection to moving DMHC here or there, but we wanted to take this opportunity to highlight that we think it has failed in part of its mission, would be our Association opinion.

COMMISSIONER BONNER: Just taking that one step further, how do you, or how would you envision bringing those two regulatory areas closer together if, on the one hand you have the Medical Board that does professional licensing and oversees the individuals or the professionals? You're not arguing or suggesting that you could regulate health plans and individual physicians under the same program, or maybe that is what you're suggesting?

PANEL MEMBER HERTZKA: No, no. No, I'm talking about different types of insurance products, like a certain PPO and indemnity insurances are dealt with differently than managed care. I mean, you know this stuff very well. You know, capitation of medical groups and all these sorts of

things.

And the physician's issues arise. They arise around insolvency, they arise around the day-to-day covering in the emergency room, but you didn't sign that contract with someone and they don't really want to pay you, but you want to provide care, you don't want the safety net to collapse. And there's really no place for physicians to go now.

And the Department of Managed Healthcare has been, in our view, unresponsive in trying to solve that dilemma. Better in the current Administration, I will have to say much better in the current Administration than the prior Administration.

But again, some of this may get beyond the details of what you're going to get to in our report. But I would just say, for those who are interested in the Department of Managed Healthcare issue, whether on this Panel, or in the Legislature, that the issues with the Department of Managed Healthcare go far beyond where you put that box in the State bureaucracy.

And I think Mr. Tough would agree that the issues go beyond that. We would have a different view on how to resolve those issues, but I think we're in fundamental agreement of holding regulation of health plans in one entity is a good idea.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, I think we've got that point.

I think we need to wrap up, we want to move to the public testimony.

So thank you all for being here and for your good comments.

We're now going to move to the public comment portion of our program, here on the beautiful University of San Diego Campus.

A few ground rules. First, we're going to permit each person to speak for three minutes, and no longer, please, in order to get to as many people as possible between now and four o'clock this afternoon. We will adjourn at four o'clock.

The young lady to my right here, and to your left, who has been helping us prompt the Panels with respect to time, will do the same thing with each person who comes up to the mike to testify.

We'd like you to keep your comments aimed at aspects of the report, any aspects of the report that you would like to comment on.

And if you have heard a previous witness essentially say the same thing you would like to say, we would appreciate it if you would come to the mike, state your name, and if there's an organization, the organization,

and say you wish to concur in the remarks of one of the previous witnesses. We'll record that for the record and then permit the next person to come forward.

So we can get to more people if we can reduce the redundancy in testimony.

If you don't get to speak, there are computer terminals in the back of the room, where you can record any comments that you would like to make, that will get incorporated in the record. I believe they are connected to the website.

And if any of you don't wish to use those, but you want to send comments, you can send them to www.cpr.ca.gov. That's www.cpr.ca.gov.

We're going to begin today with a few people who wished to testify in Riverside, and were not able to do so, and we indicated at the time that we would try to give them some priority for speaking at this hearing. And the first person I'd like to call on is Dr. Janis White.

Dr. White, go ahead, proceed.

DR. WHITE: Actually, I was not in Riverside.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, my mistake. Take it away.

DR. WHITE: Oh, no problem. Thank you all for giving me this opportunity to share a few concerns and add to some information that you already have.

(Audience feedback.)

DR. WHITE: Is this working? Testing.

COMMISSION CO-CHAIRPERSON HAUCK: There you go. The mike's on.

DR. WHITE: Really close, okay.

As you mentioned, my name is Dr. Janis White, and I'm the Chief Operating Officer with the Regional Center of Orange County. Regional Centers are State-funded organizations that provide oversight and coordination of services for people with developmental disabilities. And in Orange County we serve 14,000 people.

I would briefly like to comment on two report recommendations, which we strongly support. One is redefining the ICF Program, Intermediate Care Facilities, to include a fuller scope of services. We understand this increases federal funding that's already permitted under Medicaid waiver.

We feel like this is an ability to capture funds that are already there, that are accessible, with no negative impact on people with developmental disabilities.

Second, I would like to mirror some of the comments on IHHS responsibilities from county to State. But we would like to caution that we need to make sure that these continue to be individually tailored, locally delivered, and easily accessible.

If they aren't easily accessible, we will find that people may look at higher cost options, including institutional care or options that will increase costs. So I think just a little bit of caution with that particular recommendation.

We do agree that more federal financial participation is the key, but we also, like you, agree that we need to look at effectiveness and efficiency.

We feel like our Center, some things that have been really successful with us, that we'd like to share with you, is basically a lower service cost growth in the system. We're looking at a per capita cost in Orange County that's lower than the statewide average, but we also find that we have really good consumer and family outcomes, too.

We do a survey with the National Core Indicators. We're part of this. Orange County is alongside 22 other states to make sure that as you look at fiscal responsibility, you're not shortchanging any of the services to people with disabilities.

Thank you very much. I have additional packets, if you're interested.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Dr. White.

Next, Trini and Gerald Brown. Are they here?

MS. BROWN: Okay, I am from Riverside.

COMMISSION CO-CHAIRPERSON HAUCK: Right, thank you.

MS. BROWN: Okay. My name is Trini Brown and I'm here to speak on behalf of my family and the families in the Child Protective Services. I have many concerns, but will list only three.

In regards to the Adoptions and Safe Family Acts, revision will qualify a child to be placed in adoption. Children are being removed from parents and/or families that are qualified to keep their children or grandchildren.

CPS has removed children, terminated parental rights, and placed children for adoption from non-offending parents and grandparents who are capable, stable, and financially able to care for their children.

Juvenile Courts are stating that their hands are tied and that they must follow Legislation. Therefore, Juvenile Courts are not interested in extenuating circumstances. Juvenile Courts wants a yes or no, black and white answer. The Court is not interested in how or why.

Parents are doing what is asked of them by the social worker, attorneys, and the courts and still their parental rights are terminated and their children are placed up for adoption.

Item two, age. It states that "it takes a village to raise a child." Why, then, are some grandparents being

turned away for being able to care for their grandchildren. If it takes a village to raise a child, then the State should be required to protect the rights of the village and the federal to oversee that the state is doing what is right by the family and the child.

I'm 47 years old and my husband is 61. God forbid, but if something happened to my children and we had to raise our grandchildren, would we be told my husband is too old, so do I need to divorce him in order to get custody of my grandchildren?

Item three. Another concern is that Juvenile Court on several occasions, in another county, not where I live, county counsel has accused me of walking a fine line of professionalism and not being an expert in my field.

If a professional, that works for the same system, treats a fellow professional in this manner, then I can imagine how minorities, uneducated, and families in poverty are treated.

For example, a social worker, during a home visit, stated in front of three adults and five minor children, "single families don't get their children back because they kill them."

I am a Child Protective Service Social Worker. I have personally witnessed the abusive power by social workers, supervisors, attorneys, and the courts.

Legislation is being blamed as the causes for the injustices to these children and their families. Then change Legislation and keep these children and families together.

As families are being destroyed, so is the future of our nation. We are creating a very angry generation of children.

I do believe in the system, just not in the abuses that are taking place by those who are to protect the children and the sanctity of the family. The system is broken and needs to be fixed.

My recommendation, we professionalize the profession of social worker and make it mandatory that social workers be required to have at least a minimum of a bachelor's degree.

Number two, policy, make it uniform between counties and state, mandated and monitored.

Okay, just one more thing. I have a master's in social work and I was taught that a social worker has the power to keep a family together or tear them apart. I was reminded that on a daily basis don't abuse that power. I was taught due diligence to help each and every family as if it were my own. I was taught civil rights and not to violate them because it could be more.

Regardless of the situation, to treat the children and families with respect and dignity and not to be

judgmental. Protecting our children today protects our future tomorrow.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you.

(Applause.)

MS. BROWN: Just one more statement, everything I have stated to you today, I have court documents to support.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you.

Gerald.

MR. BROWN: Thank you. My name is Gerald Brown, and I'm here, also, to speak on behalf of --

COMMISSION CO-CHAIRPERSON HAUCK: Gerald, could you hold on a second? If you are going to --

MR. BROWN: On three different issues, sir.

COMMISSION CO-CHAIRPERSON HAUCK: All right, go ahead.

MR. BROWN: I'm here to speak on behalf of families, and my family and families in the Children Protection System, also.

I also have three different concerns that my wife did not address.

In regards to Child Protective Services, I feel it's an injustice that evidence and declarations that are in support of a parent retaining custody of their child are ignored and not investigated thoroughly.

However, declarations in court reports that are

negatively accused or defame the character of the parent is taken as truth.

For example, a court report was written one day after the social worker received the case and had not met with the child or the parent. The social worker recommendation was to terminate the parental rights and place the child up for adoption. The court granted the recommendation.

Another concern is the time factor it takes between court dates, from months to years, and the time lost between the child and the parent, and his sibling.

A social worker recommendation for visitation between the child and the parent begins at two times a week and dwindles to one hour a month, causing changes in the parent/child relationship, keeping the family separated.

CPS justifies terminating parental rights, placing the child for adoption, stating that there's no relationship between the child and the parent.

I completely believe it is in the best interest of the child and isn't detrimental to the child. What about the detriment to the nonoffending parent and/or the sibling. How can a child's blood ties be severed as if their biological family does not exist, when the system created a gap in the family originally.

Legislation's constantly cited for the reason for

the behavior by CPS for the injustices caused to the family.

Recommendation. I would recommend that it be mandatory that social workers and supervisors be required to have a master's degree in social work to understand the development of the child, coming from the education's point of view.

These social workers cite directives from their supervisors and cite that Legislation allows them to do this to their families.

Recommendation. Change the Legislation. The system is broken, it needs to be fixed. Keep the families together.

I am also a Vietnam Veteran, Army Sergeant E5, MACV, with a Bronze Star for valor, and a combat infantry badge and other unit accommodations earned in Vietnam.

I was stationed in Iniwa and was an advisor to the South Vietnamese. I proudly and honorably served my country, fighting for what I believe to be true and just. I have had to crawl through the jungles in Vietnam, risking my life for a political system in the United States that I believe in and wholeheartedly support.

It is a shame it disheartens me that I have to now fight on my homeland for political reform to right the wrongs that these families are suffering on a daily basis. Was it worth the risk?

Thank you for listening to me.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you. Thank you, Gerald.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Okay, next is Norma Pearson. Are you here, Norma?

MS. PEARSON: Good afternoon. My name is Norma Pearson, and I'm here today to ask you to put people first as on the backdrop of the map of the State of California, right behind you.

Years ago I was on the system and what I mean to say is that I was on welfare. And this is not an easy thing for me to say, especially in the public. But because of the extreme situation we're in today, with the CPR proposal of privatization of the child welfare system, I feel that it is important that I come forward with my story.

I know that many may believe that the people on welfare are just lazy and that they don't want to take responsibility for their lives. But that is just not true, they do not want a free ride.

At one time I thought that that was true, until I lost my construction company and I was forced to go on the system. My husband was gone out of my life, and I was a single parent, and I had to fend for myself with two children. For three months I tried desperately to find a

job. At that time there was no opening.

Excuse me, but it just kind of hits me sometimes, okay.

But then, finally, I got a job with the welfare system. I worked part-time, initially, with the police department, but I needed a full time income, so I took the position with the L.A. County Welfare System.

This job was a perfect fit for me because I had gone through such turmoil during the latter part of my life that I had built up such compassion for the public and I knew I would be a perfect fit for the job, so I took the job.

When I started my eligibility job, I realized then why my case load worker was a little disgruntled with me when I came into the county. I had no idea that they were carrying anywhere from 800 to sometimes 1,200 cases. That is overwhelming. They were stressed and they were frazzled.

Every EW, the kind of case work, this kind of case work, for these kind of workers, is just plain inhumane. It is impossible to achieve quality and performance productivity.

I am so glad that I'm here and I'm so glad that I took the job, because my goal at that time was to help revamp the system.

The solution to this problem of understaffing and

inefficiency is not privatization. On the contrary, that will only complex the problem and greatly reduce the need for transparency, which we so desperately need.

Without being able to examine, evaluate, and change the system of delivery we will never be able to become truly accountable and efficient, visionary and innovative.

Instead, give L.A. County, please give L.A. County the resources and the tools that we need. And also, you spoke of technology, we need that as well to help us perform our jobs.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, Norma, you need to wind up.

MS. PEARSON: Okay, thank you. Don't privatize. Thank you very much.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: The next person is Shirley Carter. And while Shirley is coming forward, I want to let you know the next three people who could get ready. Sally Kaiser-Dyer, Dottie Reiss, and Cindy Huckelberry.

So Shirley Carter. Shirley.

MS. CARTER: Yes. Excuse me, I have to be able to see. Good afternoon, my name is Shirley Carter, and I'm

also an eligibility worker from L.A. County. Most people assume that because I'm a county worker and I'm also a union member, that I'm a special interest. I'm not a special interest. I'm someone that does a job that I'm very proud to do.

We understand that there needs to be some changes in the welfare system and we've been begging for them for years.

One of the things that we heard today is that we're going to make changes. All we're asking for is a chance to be part of those changes. We have ideas that will help make the system a whole lot better than it has been. But no one, up until this time, has been willing to listen to us.

The long lines, the long waits, we understand them. As someone mentioned, some of the application forms are so complex until it takes you an extra amount of time just to help the person complete them. It doesn't make sense to have a system that is that complex.

We're here to tell you that we could help make the changes. We could make the system work, that's one of the reasons that we're here.

The people that are in the community, they're our community. We live in these communities. All we're asking for is a chance to make the system work the way the system

is supposed to work. We know how the system should work because some of us, as Norma said, we've been there.

Some of those people on those systems are our families, or our friends, they're our neighbors.

Give us an opportunity to work with you and we can guarantee you that it will work a whole lot better than what it has been. No one takes the time to ask the front line how things can work better. And trust me, we have some very good ideas. Thank you.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Shirley.

Sally Kaiser-Dyer. Here you go, Sally, take it away.

MS. KAISER-DYER: Spell my name? S-a-l-l-y K-a-i-s-e-r hyphen D-y-e-r.

I come to you from the Inland Empire, from Loma Linda University Medical Center. We have the highest death rate from cardiovascular disease of any county in the entire State, and we don't want to be number one anymore.

So I've come today to ask you to not dissolve the Task Force for the Secondary Prevention of Stroke and Heart Disease.

I have been working for the last two years with the Department of Health Services for the Secondary

Prevention of Stroke and Heart Disease and the American Heart Association, so I'm a good example of what the Governor is trying to do at the public sector, intervening with both the State and with the American Heart.

We've had wonderful outcomes in our area and my goal, as a nurse, that in the next ten years to see the death rate go down.

I was very happy to hear about this Task Force, I was nominated for it, and it's not going to cost any money. In fact, it's going to save you money.

You are spending, right now, $14.2 billion on economic burden borne by the State for medical expenses and the lost productivity associated with cardiovascular disease. And the last numbers that I have from the Department of Health Services, for the hospitalizations from cardiovascular disease, in 1999, was $6 billion.

So there really is a need for prevention in the State, and the only way that we can get federal funds for these programs is if we have a master plan, and the master plan was going to come from the Task Force. And all of us that were going to be on the Task Force were going to do this on our own time.

So it's just a very practical way to deal with a problem in the State.

I go out and give talks all over in my community,

and most people, as in this room, probably are not aware that the number one killer for women and men in this country is heart disease, and it's the number one killer of women, also. Most women will tell you it's breast cancer.

So this awareness of working on risk factors, to become personally accountable, to decrease your likelihood of being hospitalized and disabled from this disease is just something that would be a very positive thing for all of us to work on together.

So I plead with you to please not let the Task Force be put aside, because it won't cost you any money. Thank you.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Sally.

Dottie, you're on.

MS. REISS: I'm Dottie Reiss, and I'm here about that same Task Force, with a little different point of view. I'm the President of Mended Hearts, here in San Diego, and Mended Hearts is an organization of heart patients and their families. We provide support to those heart patients.

And we are the second largest support group in the United States, right next to A.A. Mended Hearts has been here, in San Diego, for about 30 years and we have over 300 members.

I want to tell you about my husband, Richard. I'm the President of Mended Hearts because he was the President of Mended Hearts. And one year ago this month Richard died of a massive heart attack. But Richard was the President of Mended Hearts because back in 1980, when he was 45 years old, he had a heart attack, and he survived that.

And because of the kind of research, the kind of education, the kind of technical things, and all that was going on, he was able to have not only a bypass, but be able to change his lifestyle to understand what he needed to do, to do that. The only thing he did wrong was pick the wrong parents. But after that he lived another 22 years, a very vigorous life.

And I tell our Mended Hearts now that they're probably fortunate that they have heart disease, because it's one of the things that so much attention is being given to. I tell them that they're at the right time and I hope, now, the right place, California, to be living with heart disease because so much is being done in the area of treatment, and research, and prevention, and education.

There is a momentum and, actually, our own Governor was a role model for my husband, and he was a role model for many of our members on how to survive after a heart incident, and he certainly has built himself a better life since his heart disease. And that's what we say for

most of our patients.

This kind of education and continuum, this was a momentum until just recently, and it really needs coordination because there's so much going on. And that's what the Task Force, their first charge was to do the coordination of all the kinds of education, research, and treatment programs for heart and for stroke patients.

And we need the master plan. We were denied money. This Task Force is totally privately funded, so it's not a cost-cutting measure to cut it. But actually, it could bring revenue from the State. We were denied money from the CDC, up to a million dollars we could have, if we had in place a master plan in this area. So it would bring money into the State.

I wanted to tell you that the Heart Association has those little red pins for you. And I hear the dinger. The little red heart pins, they're little red dresses and they're to remind you that women get heart disease, too. And we'd like you to wear them and enjoy them. It's not a bribe, but just keep in mind that heart disease does need this Task Force. Thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you, Dottie.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Okay, Cindy, am

I saying this correctly, Huckelberry, Cindy?

MS. HUCKELBERRY: I'm the only family in the United States of Huckelberry.

With you all, I believe you have the Study of the Negative Impact of Child Protective Service, I believe you'll have it with you, or should, somewhere in your paperwork.

I've been a registered nurse for 21 years. My mother was a CPS worker for the State of Illinois for 20 years, so I sort of grew up with CPS. And I hold a master's degree.

Child Protective Service was designed to protect children and aid families that are in need of assistance, in order to maintain the family unit.

Unfortunately, today, we are finding that CPS is targeting families with limited set budgets, where child removal is commonly practiced for their personal financial gain.

This dispassionate behavior exhibited by caseworkers towards the impoverished families they serve promotes further devaluation of their lives.

Due to Child Protective Service's lack of understanding and caring related to the circumstances of these financially challenged families, this stereotyping creates further dissention, thereby resulting in prejudiced

decisions.

In May, I chose to do an informal study, because of my own situation, which I'll talk about last, because I'll get upset.

But anyway, I had 55 families at the time. I have many more right now, but 55 families, 135 children. All children were placed in Foster Care. Through the utilization of Child Protective Service's Codes, policy, procedure books, I obtained them and I went through these cases, myself.

I found that only two cases out of the 55 cases met CPS's criteria for removal. The majority of the cases mainly needed services and assistance with some aspect pertaining to life experiences.

Only one child out of the 135 has ever been returned. I found that, especially in San Bernardino County, Riverside and L.A., I've had cases from all areas, mainly San Bernardino, the CPS targets poor, disabled, elderly, and under-educated.

Parents, guardians unfamiliar with the law, with limited or no financial means to secure impartial, unbiased legal representation, blindly trust CPS and the courts. Therefore, Child Protective Service is able to manipulate the court system to secure foster care and/or adoption status of these children for profit.

And when I mean profit, in 1997 Clinton enacted the Safe Families Adoption Act to provide bonuses for these individuals if you found -- for the adoption process.

So what we found, or that I found, that these workers, to buck up their budgets in the county, they get $8,000. Every time a child's adopted out, they get $8,000. This is all for profit. They mainly target the poor, under-educated.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, Cindy.

MS. HUCKELBERRY: Okay, Sorry.

COMMISSION CO-CHAIRPERSON HAUCK: You're going to need to wind up here.

MS. HUCKELBERRY: Okay. Well, lastly, my own situation. I have monitored visits with my son. Those have been discontinued a few weeks ago. The reason why I have monitored visits for the last five years is that, a common practice that is utilized through CPS, when they're not allowed in Family Court, they come in and they are the tool that the Family Court System utilizes to pull children from usually the mother's custody to the father's.

This is usually related to fathers not wanting to pay child support. And this can be verified through the FBI, Brenda Atkinson.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, Cindy, you have to conclude.

MS. HUCKELBERRY: Okay, that's more or less, it's just someone needs to come into San Bernardino County, in particular, because their numbers are so far off from Riverside and L.A. that, hopefully, someone can come in and do an audit and then see what in the world these people are doing.

COMMISSION CO-CHAIRPERSON HAUCK: Okay.

MS. HUCKELBERRY: But I think you're going to find the same things that I have. Thank you.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Okay, the next folks, Jerry Desmond, Jr., first. Ray Mastalish, next. Nancy Dolton after that. And then San Diego City Council Member, Donna Frye.

So Jerry Desmond.

MR. DESMOND: Hello, good afternoon, I'm Jerry Desmond, Jr., with the firm of Desmond and Desmond. And if I could go back for a second to last week, I was with the Infrastructure over there in Riverside. We didn't have a chance to talk about Recreational Boaters of California and the proposed Boating and Waterways Division.

First, I represent Recreational Boaters of California, 75,000 boating families belong to 190 boating and sailing clubs throughout the State. And we appreciate and acknowledge the effort the Commission is doing here

today, as well as Governor Schwarzenegger's initiative to reexamine State Government and accomplish new efficiencies and new effectiveness for the State. We applaud the efforts.

In terms of the Boating and Waterways Department that exists today, and the proposed Division of Boating and Waterways, first we are pleased with one aspect, and that is that it would be a Division in the Infrastructure Authority.

And then we have some comments in terms of what that would mean in terms of boaters and some suggestions in terms of the Commission's input into the recommendations.

First is that one of the issues you're struggling with, it appears, at the Commission level here, is whether the effort to accomplish efficiencies will sacrifice expertise and effectiveness.

The Boating Department that exists today, and as it would shift over to a Division, represents that kind of an issue for you, we believe.

Today, the Boating Department consists entirely of $90 million of boating fees, taxes, interest back on loans and Federal Fuel Tax dollars. There is no General Fund support for the Boating Department.

If it moves into an Infrastructure Authority, as a Division, then one of our primary issues is, is the funding that would be devoted to the Boating and Waterways Division,

is it going to be kept intact, is it still going to be returned to boating activities, services, and programs?

As we heard more elaboration last week, in terms of the Proposed Authority, there were questions by some of the other Divisions in terms of what would be their expertise on a new Authority amongst eight appointees, with a consolidated structure at the staff level.

As a Boating Division, competing with a Telecommunications Division, a Water Division, an Energy Division, and a Transportation Division, you can imagine that our issues might be exacerbated in terms of what kind of role the Boater Gas Tax dollars would have with competing resources.

So we would suggest that steps be taken to ensure that in the Authority structure that there is a preservation of boater-derived funds and fees, a dedication to the programs and services, and acknowledgement that there are more than infrastructure activities that are engaged upon by the Boating and Waterways Division. There's boating safety, there's boating environmental protection, and there's boater education, and would those be sacrificed in terms of infrastructure.

And then the final comment, and I'll close, is that the Boating and Waterways Commission, a working Commission, with no General Fund dollars and no fees, if

it's sacrificed would there still be the public input that's necessary to ensure that the proper role of the State is carried out.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you, Jerry.

MR. DESMOND: Okay, thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Ray Mastalish.

MR. MASTALISH: Thank you. My name is Ray Mastalish, that's M-a-s-t-a-l-i-s-h.

COMMISSION CO-CHAIRPERSON HAUCK: Sorry, Ray.

MR. MASTALISH: I'm currently the Deputy Director of the Riverside County Office on Aging, although I'm not here speaking on their behalf or on behalf of Riverside County.

Up until last month I was the Executive Director of the California Commission on Aging, prior to that serving as a Commissioner, appointed by Governor Wilson for seven years. Prior to that I was Executive Director of the National Association of Area Agencies on Aging, in Washington, D.C., and Assistant to the Commissioner, of the Administration on Aging, at the Federal level.

I'm submitting a written statement which implores you, and I'd like to give it, which implores you to look at alternative proposals that are being worked on simultaneously. You heard about the Little Hoover

Commission. But also, look at recommendations that are coming from committees, that Assembly Member Patty Berg and Assembly Member Daucher have put together, with the Assembly Committee on Aging and Long-Term Care, to look at how we provide services and information to seniors in the State of California.

Also, look at the Commission's proposals or response to the Legislative Analyst's Office Proposal on Restructuring.

But I'm going to divert a little bit here and ask, where has the State's commitment to the senior citizens gone? It's not reflected in your invited panels, and it's not reflected in the CPR report.

We heard last week that one goal of this process was to improve services to our consumers, the citizens and taxpayers. This proposal, in my judgment, fails to do that.

One, it simply moves broken boxes around. Certainly, it doesn't blow them up. Fragmentation will continue. The proposal restructures around fund flow, not around what is best for the consumer or those providing services to the consumers.

Seniors, caregivers, and providers will still have to deal with multiple departments and units in the new organization structure.

Second, there is a basic flaw in the CPR process.

Constructive reconstruction historically does not come from within a bureaucracy. While I commend the 275 dedicated Civil Servants who worked on this report, this is, in itself, a flaw.

My personal experience with the person who interviewed me for over two hours, wore her bias on her sleeve. The report reflects that bias.

Third, the California Commission on Aging. Last week, you heard Mr. Schachter point out that the Commission has no State funds, yet the CPR recommends that it be wiped out.

This is the only mechanism at the State level for providing leadership, policy leadership, advocacy into the system.

While the report says the Secretaries can establish advisory bodies, let me ask, if the Commission on Aging had been located in Health and Human Services Agency, do you think it would have been able to join with Senator Burton and Assembly Member Hertzberg in a lawsuit against the energy providers and FERC, during our energy crisis, which had devastating effects on seniors on fixed income.

Do you think it could have issued a statement, calling on the Governor and the State Legislature to explore prescription drug purchases from Canada, which would save the State millions, and millions, and millions of dollars.

You know the answer, it is no.

I ask, where's the consumer and the senior voice in all of this, and I implore you to get the consumer, as Assembly Member Bates said this morning, get the consumers to the table, get those who are first line providers of services, you will hear what it's like dealing with this bureaucracy.

Thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you, Ray.

Nancy Dolton.

MS. DOLTON: Good afternoon, Commissioners. The spelling of my last name is D-o-l-t-o-n, Nancy Dolton. Thank you.

I am the Chair of the California Commission on Aging, and I would like to share with you some thoughts that we have on the proposed structural reorganization of the Department of Health and Human Services.

We most certainly commend the efforts to improve the current fragmented system of programs and services for aging in California, from both an administrative and a consumer perspective.

A key and major component of any restructuring in the State of California must include the impact on an aging society, specifically the increasing numbers of older

adults, and specifically minority older persons will affect the provision of services and programs statewide.

Older persons in this nation are no longer a special needs target group, but have become a major part of mainstream society.

Similarly, in California, older persons are impacting services and programs across the State infrastructure well beyond those currently provided by the Department of Aging. The social, the economic, and political ramifications are tremendous.

These dramatic demographic changes will require diligent coordination of programs and services, and active participation of expert advisors, selected from the community at large, to ensure efficient and effective delivery of services.

We feel that it is essential that a successful State administrative structure for aging programs and services include a strong focal point for aging at the State level, that has both independence and authority to perform the following functions. And there are seven of these, and I'll run through these really fast.

Fulfill the role of a spokesperson and advisor for aging policy to the Legislature, Governor, and Health and Human Services Agency.

Determine constituent input and provide a voice

for senior concerns.

Advocate on behalf of the four million plus seniors in California.

Plan and design a service delivery system that meets the challenge of California's changing demographics. And here, again, I'm talking to you about the Baby Boomers.

Coordinate services across State departments and agencies that impact on older adults and individuals with disabilities, building on what we already have done to begin to streamline programs, but look at where we go from here.

Ensure the greatest, most efficient, effective, consumer-friendly use of State resources. And let me say, beyond all be concerned about preserving the dignity and integrity of older persons.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, Nancy, you need to wind up.

MS. DOLTON: I will, just in a moment.

COMMISSION CO-CHAIRPERSON HAUCK: No, you need to wind up, Nancy, please.

MS. DOLTON: I will. I want to say, again, that the California Commission on Aging receives no State funds, we are federally funded. Thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Nancy.

Okay, next, Donna Frye. Is Donna here? Okay.

MS. FRYE: My name is Donna, D-o-n-n-a, Frye, F-r-y-e. Thank you.

I wanted to thank the Commissioners today for the opportunity to comment today, and I'm here today representing myself, a Council Member for the Sixth District, in the City of San Diego, as well as the Mayor of the City of San Diego, Mayor Dick Murphy.

And again, I appreciate the time that you're willing to spend here, listening to the public's comments.

While we appreciate that the CPR is working to improve State government by increasing efficiency and reducing costs, we must express our strong concern about some of the proposed recommendations for safeguarding our natural resources.

We believe that it is okay to streamline the bureaucracy, but not at the expense of democracy.

The first resolution that we would like to address to the Commission is the opposition we have regarding the elimination of the San Diego River Conservancy. The CPR is recommending that the Conservancies of statewide interest be retained, but that does not include our San Diego River Conservancy.

We believe that the San Diego River Conservancy is of statewide concern. People have lived and been dependent on the San Diego River for over 8,000 years. In the 1700's,

the European settlers utilized the River, with one of the first span of settlements in California being constructed along the River.

And in 1769, Father Juan Crespi wrote a letter from San Diego, which reported back to Spain on his travels, "if the River is permanent, it may prove in time to be the best of those discovered in all of California."

Last year, San Diego River Conservancy Area welcomed over 26 million visitors. In 2003, visitors poured over $5 billion into the economy, making the visitor industry San Diego's third largest.

The San Diego River Conservancy is of statewide concern and should be retained, and there's many people here today, in the back, who will stand up just to let you know that there's a great deal of interest for this.

The second issue today, that we would like to address, is Resolution Number 10, which is the proposed consolidation of the State Field and Regional Offices for the Water Resources Control Boards.

It appears that the CPR is recommending that the water quality functions of the State Water Resources Control Board and the Regional Boards be combined and transferred to the Division of Water Quality.

We oppose this recommendation. The Regional Water Boards are an invaluable resource to the local communities

for protecting and preserving local waterways.

The State Board and the Regional Boards practice government in the sunshine. The Regional Board meetings are in the San Diego Region and, therefore, enable full public participation. Due to the open public decision making process, in a local forum, the community also knows and understands why and how regulatory decisions are made.

The proposal to turn these critical decisions from local and public, to the inside of the halls of government in Sacramento will be a step backwards in CPR's stated vision of government accountability.

One last final sentence. As CPR states, California's State Government should reflect the decency, integrity and honesty of the people it serves. In order to accomplish that goal, we must maintain our State Board by putting people first.

Thank you very much. And I would just like to submit the written comments from the Mayor and Council. Thank you so much for your time. And if you get a chance, while you're in San Diego, please go check out the River, I think you'll have a good time.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Donna.

Next, Wayne Doss. And after Wayne, Jose Pulido.

MR. DOSS: Good afternoon, Members. My name is Wayne Doss, I'm the President of the Association of Child Support Attorneys in Los Angeles County, a Nonprofit Association, representing public sector attorneys working in the child support program.

I'm here to address the CPR recommendation regarding privatization of local child support agencies.

First, I want to suggest to you that it is premature in this point in time to be talking about a major change, such as privatization, only five years into a major realignment that was accomplished by the Legislature and the Governor in 1999.

As you heard from Mike Herald, at the Western Center for Law and Poverty, earlier today, that realignment is already paying off in big ways, ways that are not reflected in the CPR's report, and we would be happy to engage the Board with information about the improvements that are being made, beyond those that were discussed by Mr. Herald.

For that reason, alone, I think it's probably untimely to be talking about privatization. But I think there's another, far more compelling reason not to do that. The reason is that California has recently embarked on a $1 billion automation effort. We've entered into a contract that will not be terminated until probably 2008, to build

the largest computer system for child support automation in the United States.

California is already seven years behind the federal deadline to have that automation system in place. We have paid over $700 million dollars in federal penalties, to date, for not having that system, and we are paying $200 million a year until that system is built.

On top of that, California is about to undertake another major automation effort in the Child Support Program, and that is to build a system that will receipt and disburse child support payments to the families that receive Child Support Services in this State. That contract will cost over $150 million.

Both of these automation efforts are staffed and supported, to a large extent, by staff from local child support agencies, which have the operational understanding around the running of Child Support Programs, that has historically been lacking at the State level.

I suggest that efforts to fully privatize local agencies, at the same time that California is depending upon those agencies for support in developing and implementing two major automation-related projects, presents a recipe for not only costly delays, at a minimum, but potential failure, at worst.

Standard risk analysis suggests that undertaking a

realignment as significant as that contained in the CPR recommendation about privatizing local child support agencies, while engaged in a massive complex computer development greatly increases the risk that both efforts will fail.

A slippage, from one fiscal year to the next, in the timeline for the development of the statewide automation system, will cost California more than $200 million. That's almost two and a half times the entire savings that the CPR says it will find over five years, from its recommendation to privatize.

Thank you. One other thing, and I'll close here, there are lots of other ways that we can find savings in this program and make money for the taxpayers in California. We would love to engage the Commission in those discussions. Thank you for your time.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Wayne.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Jose Pulido is next. And after Jose, Michael Sise, S-i-s-e, Sise. Gary, is it Vilke. Mary Sullivan, from San Diego. So after Jose.

COMMISSION CO-CHAIRPERSON HAUCK: Is Jose here?

MR. PULIDO: Yes, sir. It's P-u-l-i-d-o.

Good afternoon, I'd like to thank Yahwei, our

Creator, for this opportunity to address this august body.

My name is Jose Alfonso Pulido. I just lost my wife of 25 years to asbestos form cancer. The Lord blessed our union with three beautiful daughters and three wonderful sons, the oldest of which is currently engaged in battle outside of Baghdad.

I fear for our boy's safety. However, this fear pales in comparison to the sheer panic at the premise of my wife's untimely death, putting my children and myself at risk of becoming statistical victims of overzealous and malinformed CPS policy enforcers.

We, the people, we must ensure the maximum optimality through a tangible capital minimum. In view of the lack of financial stability throughout our Golden State, we sorely need to evaluate the counter productive misuse of funding being carried out at an appalling rate where it pertains to our ill-run Child Protective Agencies, engaging in blatant disregard for proper protocol, and the lacking or exclusions of human compassion paramount for all involved in these very delicate social matters.

With proposed issues, in particular, 408, S409, this bill provides loan forgiveness to social workers who work for our Child Protection Agencies. This said bill was introduced in February of 2003, and it's detrimental to our State's financial soundness and it threatens the very fabric

of true family life.

We have inadvertently replaced the most noble endeavor with these types of monetary incentives. Through these misguided attempts and these social instabilities, let's please reaffirm our prime incentive, and that would be the restoration of our nation's truest resource, the harmony and integrity of our children and their biological families.

Thank you for your time. God bless America.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Jose.

Okay, Michael Sise. Am I saying that correctly?

DR. SISE: Yes, sir. I'm Dr. Michael Sise, I'm the Trauma Medical Director at Mercy Hospital, a level one trauma center, and the busiest center here, in the San Diego County Trauma System, that's 20 years old.

Please don't burden Homeland Security with the MS. I think you need to think very carefully about the implication of what could happen. Think about it. It's a year from now, you're visiting San Diego, you get into a bad car crash, you've got a bad head injury and a broken neck. That ambulance, with that paramedic that picks you up, that paramedic has to make careful decisions about your head injury, about starting an IV, about whether to put a breathing tube in to support your breathing, how to handle your neck so you don't injure your spinal cord.

That paramedic brings you to my trauma center, where one of my trauma surgeons, that meets the county standard and the State standard will treat you, and then call a neurosurgeon, whose certification, quality is monitored by our partners in this public/private partnership, that's created the San Diego County Trauma System in EMS, has to monitor that neurosurgeon's training, education, and excellence.

Homeland Security is something we live every day and are prepared to support every day. We are important partners.

A good friend of mine, who's the Chief of Trauma at Bellevue, and gave a very compelling report of what it was like to handle the thousand walking wounded who came from the World Trade Center. We studied this, we're prepared.

EMS is a complex contact sport, day in, day out, night after night, and involves sophisticated medical oversight. You can't, if you think about it, transition from Homeland Security being responsible to what happens up to the door of the emergency department of the trauma center, and then have Health and Human Services be responsible for everything that happens inside, except for if it's a trauma center, then it's Homeland Security.

I would ask you to carefully consider not trying

to fix what's not broken, what has evolved in a very resource sparse environment, which stands in California as something we do extremely well. Please keep EMS, an important and well-run division, within Health and Human Services.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you, Doctor.

Is it Gary Vilke, is that correct?

DR. VILKE: It's Gary Vilke.

COMMISSION CO-CHAIRPERSON HAUCK: Vilke, okay.

DR. VILKE: V, as in Victor, i-l-k-e.

COMMISSION CO-CHAIRPERSON HAUCK: All right, Gary.

DR. VILKE: Good morning, thank you for letting me speak. I'm a Board Certified Emergency Physician, and I'm here today speaking on behalf of the EMS Medical Directors Association of California, MDAC.

MDAC members are physicians who medically direct the EMS systems across California, in accordance with the State statues and regulations, under the leadership of the State of California's EMS Authority.

We applaud the Herculean effort of this California Performance Review and recognize the challenges that are faced in putting such a review together, and its recommendations, as well.

MDAC would, however, like to point out that are likely what are just some oversights, and really end up being some critical issues with regards to maintaining our emergency care systems statewide.

While MDAC fully supports the concept of streamlining government, we cannot support the recommendation of the California Performance Review that the EMS Authority be transferred to the Department of Public Safety and Homeland Security, within the Fire and Emergency Management Division.

We strongly feel that EMS Authority needs to be aligned with a more medically related department, with appropriate physician leadership. It should maintain its autonomy and remain intact, as an intact Division within the Health and Human Services Department.

The EMS is a medical service. It requires the leadership of EMS physicians to achieve the highest levels of evidence-based medical care. In current statute and regulation this physician leadership is coordinated by the Physician Director of the EMS Authority, in conjunction with the Physician Members of the EMS Commission.

The current CPR Reorganization Plan fails to explicitly maintain this physician leadership in California's EMS system. This serious oversight must be corrected.

Additionally, EMS is a distinct medical discipline that crosses many boundaries, pre-hospital systems of care, emergency departments, poison control centers, and as we heard, the trauma system, as well, are all parts of California's EMS system under the leadership of the Authority.

In closing, I must reiterate that we cannot support the recommendations of the California Performance Review that the EMS Authority be transferred to the Department of Public Safety and Homeland Security, within the Fire and Emergency Management System.

Thank you for your time.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you, Gary.

The next is Mary Sullivan, and after Mary we have Gail Johnson, Dan Kysor, and Angela Gilliard, I believe this is, probably from the Western Center.

Okay, Mary.

MS. SULLIVAN: My name is Mary Sullivan and I'm a consumer. I feel qualified to speak today because I've lived in California and worked for the State, for the colleges, for the California State Assembly, in law offices, and in the Governor's Office in the State of Washington. I am educated both in California and Washington.

The report says the State is ailing and the

solution is to consolidate. But the State is ailing for more than one reason, mainly lack of money and a qualified work force.

Report staff used other state's programs as reasons for why California should use the same methods, yet it is neither inventive, nor bold, to compare California to other states, none of whom have a population of more than 7 million.

Boom and bust spending can be traced directly to energy deregulation in California, not just inefficiency in government.

Staff also used Utah, with a population of over 2 million, for automating driver renewal in California. However, 84 hundred thousand people, using a system out of 35 million is hardly worth implementing.

San Diego DMV. Recently, I made five trips to DMV to get one driver's license and one set of license plates. I was given a license with a legally incorrect name. I was told to get my vehicle weighed, when I didn't need to. I was over-charged fees because I wasn't asked the right questions. I tried to call and got an automated voice that hung up when my need didn't meet their four-button choice of agendas. Each time I had to wait close to one to two hours to get served, not 30 minutes, like the report states.

Most of the employees went to lunch at the same

time I was there, leaving cubicles empty with scores of people waiting.

All these problems have to do with bad management and bad work ethics that no amount of converging departments will change.

General report suggestions. Students, receiving Cal Grant awards, should be required to perform internships with State agencies, thereby giving them job experience, public service entre, and added help for State agencies.

Two, individual agency hiring managers should hire people with skills, education, aptitude, and the correct work ethnic. Involving the Governor, as the report suggested, is an inefficient use of his time.

Three, in order to hire employees with the above skills, higher ed. should be required to teach ethics, philosophy, and critical thinking.

Four, DMV needs more, not less service centers, and better, not less employees.

Finally, to state they're raising taxes doesn't make sense, as the report says, is ludicrous. The cost of living has increased, it costs even more to run the State. Therefore, common sense says the State needs to increase its income base.

Denigrating workers, forcing double work loads, less benefits and less money doesn't get you private sector

results.

Let's really be innovative, let's not just reorganize, let's also pay for what we expect to get in the society we live in. California should be a leader, not following what other states do.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you, Mary.

Gail Johnson is next. And after Gail, it's Dan Kysor.

MS. JOHNSON: My name is Gail Johnson, I'm the Executive Director of Sierra Adoption Services, a private, nonprofit adoption agency, specializing in finding permanent adoptive families for children in the Foster Care System, specifically children who are most hard to place.

We're nationally recognized, through a Presidential Award for Adoption Excellence, and increasing the number of adoptions of children with special needs, and currently are privileged to serve as the lead agency for CDSS's federally-funded demonstration project to find permanent families for California's Foster Teens.

We have four previous public/private partnerships, as well, federally-funded, which produced stunning outcomes, including, in one county, the increase of adoption of their foster children by 800 percent.

It's from these experiences that I formed my testimony today. I'm very pleased that the Commission sees that increasing permanency for children in the Foster Care System is important.

I'm concerned, however, that some of the recommendations may cause unforeseen negative consequences in the chances of our children achieving permanence.

Specifically, in realignment, I want to be sure that you take a look at how realignment of foster care to the counties impacts the Adoption Assistance Program, which is currently a different sharing ratio than for foster care. We specifically created an incentive for the counties by having a lower share of cost for the AAP Program. So AAP is not included in the recommendation. But if it's all realigned, that incentive will be lost.

If, on the other hand, the State keeps AAP at a higher share, it makes it a higher cost for the State, if children are adopted, and that has prevented Legislation which would get kids placed, so please be careful about that.

Also, we really applaud eliminating the duplication of fingerprints for foster families, who are adopting their foster children. However, there are two standards of information that are provided for fingerprints for adoption and foster children. Please keep the higher

standard.

Families who adopt, the fingerprints include information about arrests, as well as convictions, and we need to know if a family has been arrested five times for domestic violence, when we determine whether or not they can be adopted.

I've submitted written testimony that I'd like you to take a look at, because there isn't time for it all. But there's a number of recommendations that need to be considered so that we can, in fact, move our children towards permanence, whenever possible, to their birth parents, when not to safe, healthy, permanent, loving families.

Thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you, Gail.

Dan Kysor. Is Dan here?

(Audience feedback.)

COMMISSION CO-CHAIRPERSON HAUCK: Okay. The next is Angela, I think it's Gilliard. Is Angela here?

MS. GILLIARD: I'm here.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, Angela.

After Angela is Gregory Knoll, and then Patricia Diaz.

MS. GILLIARD: Angela, A-n-g-e-l-a, Gilliard, G-i-l-l-i-a-r-d. I'm the Legislative Advocate for Western

Center on Law and Poverty. And we've already submitted extensive comments to the Committee.

I just wanted to bring out just one small point, and that is we didn't comment in our public comments about the HHS Recommendation 23, which is to streamline oversight requirements for conducting Medi-Cal survey audits of health plans. And this is a recommendation to the Governor to work with the Legislature to require the State to use the results from accrediting organizations, where they are equivalent to or exceed the State standards regarding medical surveys, audits, and so forth.

And the primary problem with allowing a private, non-governmental, outside entity to substitute for State Regulation is that it is not accountable to the resident of California. Therefore, it would not be possible to control or even know whether outcomes were improving.

If there were signs of trouble, what would we do, how would we even know?

The work of these accrediting entities is not public. Would we have to wait until enrollees start having complaints and having real problems?

The other thing I wanted to just bring out real briefly, is the fact that in reading the recommendations, at least in the health sections, there were a number of workgroups that were recommended between basically

government officials.

And what was lacking, in my opinion, is the input of advocates in these workgroup processes, as part of the recommendation from the CPR Committee.

So I would hope that there would be more voice of the advocate community, and the consumer community, and the clients who ultimately have to use these services.

Thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you, Angela.

Gregory Knoll.

MR. KNOLL: Yes, thank you. My name is Gregory Knoll, K-n-o-l-l. I am the Executive Director and Chief Counsel of the Legal Aid Society of San Diego, and also of its Consumer Center for Health Education and Advocacy, which is part of the Health Consumer Alliance, a group of seven legal aid programs and two support centers, funded by the California Endowment, to advocate on behalf of individuals and families in need of healthcare.

Also, locally, I Chair the Healthy San Diego, which is our Medi-Cal Managed Care Model, Oversight Advisory Committee. And I have been struggling with being here since 8:30, like you have, and trying to think of what two minutes could be of major impact to you, and I decided that there was not much.

So I asked everybody else, and they said if I had two minutes, I should spend it trying to disabuse you of any belief that the Health Families Program should be used as any kind of a model for administering any kind of healthcare.

I will say that the best thing about the Health Families Program and MRMIP is that they have been willing to work closely with advocates to talk about how to fix problems.

But if you are going to use Healthy Families Program as the model, let me assure you of a couple of things. Applications are regularly processed incorrectly, confusing parents as to eligibility and coverage dates. Incorrect notices is a constant problem.

Initial payments are to be made at application. Checks are cashed, clients assume that coverage is in place, they are disabused of that when they get the health bill.

Different administration for the checks versus the applications.

Access to toll-free lines about application and renewals is a joke. I must tell you, the first time I hear a San Diegan say that they've been helped by the toll-free line will be the first.

Delays in processing applications and renewals. Incorrect terminations due to lost premium payments,

accounting errors, or delays in sending out forms or notices. Confusion with the appeals process.

There should be no confusion with the appeals process. Goldberg v. Kelly, and all of its progeny, explain what an appeals process should be with any program where you have to do a litmus test for government funds.

Problems with timely enrollment of eligible children into correct managed care plans, problems with letters and notices. MCCSMS and MRMIB need to provide training to staff, assign specific liaisons, and give certain staff authority to resolve problems quickly, a process for identifying and correcting systemic eligibility determination errors that occur time and time again, and they need to develop a more effective working group with advocates, the CWDA, MRMIB.

And finally, if you would really like to jump outside the box and think about a way to save money, if that's what this is all about, I have an idea for you.

Take all the money that you have spent on healthcare in San Diego, take five percent off. No, take ten percent off, then cut a check, made out to me, Robert Hertzka, Dr. Michael Sise, Steve Escoboza, and we guarantee you, if you stay out of our way, we will guarantee quality health coverage for everybody 400 percent FPL and below.

Thank you very much.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: Thank you.

The next is Patricia Diaz. After Patricia is Dion LeVar, and we'll see where we are at that point.

MS. DIAZ: My name is Patricia Diaz, I'm with the Latino Coalition for a Healthy California. LCHC is also the Chair of the Latino Health Alliance, which consists of statewide organizations dedicated to the health and well-being of the Latino community.

So today I'm speaking on behalf of the Latino Health Alliance. In your binder you have the written testimony for LCHC, along with some of the proposals that we support in principle, those that we are opposed, and then those that we are greatly concerned and we are requesting for some more detailed information.

Today, what I wanted to do, was to really discuss that as the details are being developed with the Administration, Legislature and stakeholders, we really need to be mindful of promoting low income families' access to health services, while improving government efficiency.

The Latino Health Alliance has created the following guidelines that I'm going to go through, and I might not have time to go through all of them, but they are in your package.

The first one is that the changes to Health and Human Services, they really require a more thorough and thoughtful analysis by the impacted State departments, Legislators, and stakeholders.

The Latino Health Alliance is calling for an open process in the development of the details, that involves representatives from the Administration, Legislature, and stakeholders.

We're also calling for additional hearings to be made available to the public. We really think for a true hearing to gather public input, it is critical that public hearings be made in several different regions to assure these hearings are made accessible for the low income population and nonprofit organizations representing key constituencies.

Number two, low income families, children, seniors, and developmentally disabled must be a priority. While California will be experiencing a structural budget crisis of $10 billion in the next two years, Latino Health Alliance calls that government services for low income families, children, and individuals are not sacrificed in the development of the details to close this budget deficit.

Number three, special populations must be considered when developing the details of the recommendations. Health and Human Service Programs serve a

diverse population with special needs. Proposals must consider the need for culturally and linguistically appropriate services for immigrants and communities of color.

Continued access to Family Planning Services for women, and access to safety net services for the un- or under-insured population.

Sensitivity to the use of the technology must be addressed. When proposing the use of technology, consideration must be made regarding a recipient's literacy level, English proficiency, awareness of technology, and privacy issues.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, Patricia, you have to wind up, please.

MS. DIAZ: Proposals must address how to resolve these issues to ensure that additional barriers are not created to enrollment, access, or utilization of services.

Thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you.

Dion Levar.

MS. LEVAR: D-i-o-n, Levar, L-e-v-a-r.

First of all, I want to thank you for hearing me speak, and I want to thank the people that I came with, that gave me the ride to come here and express myself.

I'm speaking to not just a Panel, but people that

are parents, and my situation is concerning CPS, and the practices that they are allowed to do to bring down the emotional and mental stability of our children, our parents, us, as parents. The disregard that they have for State law, their own laws, and their own procedures and how they handle each case.

My children have been taken away from me, it's been two and a half years. And I'm disabled and I'm also in poverty, as well. And the reason why that I'm making you aware of this is because I've overcome the depression and the environmental place that they have put me.

I was a wife, a homemaker, and I had no education, except for my high school. And I've gone back to school now and I've done basically everything that they've asked me to do.

And I've seen my children cry time and time again, and I've cried to release my children and to bring them home. And they just won't. They won't let go of my babies. They have my children because of money and it's always been that way. It is our children that suffer.

This is the next generation that counts and I'm begging and pleading that the Governor, and each one of you listen to the hearts of these families, and watch and see what happens behind closed doors.

I thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, thank you, Dion.

(Applause.)

COMMISSION CO-CHAIRPERSON HAUCK: All right. Finally, is Barbara Barron here? Is she here? Okay, and we will conclude with Barbara.

MS. SIEGEL: If I may, I'm not Barbara, she's a good colleague and friend. But I'm Patty Siegel, from the Childcare Resource and Referral Network. I've been here since 8:30. There hasn't been one witness on one Panel, or anywhere today, addressing the significant and profound changes that are suggested to childcare. A little bit of Catherine Teare's, but that's all.

And I would beg you to please allow me to at least alert you to those issues. I've provided written testimony. But I think it's an outrage that those of us who have been here, and waiting since 8:30, I appreciate that you took a lot of other people, but please extend the time at least so those of us, and those issues that have had no hearing, and no representation that affect our youngest citizens can be heard.

I thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, I appreciate the statement. But we've made it very clear that we are going to conclude at four o'clock. And folks are

more than welcome.

MS. SIEGEL: She's giving me her time.

COMMISSION CO-CHAIRPERSON HAUCK: Okay, then you can proceed.

(Audience feedback.)

COMMISSION CO-CHAIRPERSON HAUCK: Folks, the more time -- would you go ahead and proceed?

MS. SIEGEL: Yes, thank you. I welcome the opportunity to address you, and we have provided written testimony, it has a logo with kids on the top, California Childcare Resource and Referral Network.

Our job, as a statewide organization since 1980, is to help millions of parents throughout California, all types of parents, from all income levels, access the quality childcare services they, and all of us need, who are parents, who work. We depend on quality childcare. So the recommendations before you are profound.

I'm afraid that it's a bit significant that childcare has been so eclipsed by the overwhelmingly important issues that our Department of Health and Human Services must address.

And every bit of testimony has been important, but I think there's a message, and I think the message is that childcare services don't belong in the Department of Health and Human Services.

(Applause.)

MS. SEIGEL: They belong where they have long been rooted, partially rooted, in our Department of Education since World War II.

You did open with the profound comment that the childcare system in California is cumbersome and complicated. And as an advocate and parent who has lived on the border of those two systems, since I began the childcare switchboard in San Francisco, way back in 1971, when my twins were a year old, I can tell you those borders are challenging.

But there's a reason that we have two systems, and that's because unlike almost every other state in this country, we have seen the value of children learning and parents earning, a dual goal.

Not just the CalWORKS system where we find something, find some kind of childcare, somehow, someway. We understand what other states are coming late to learn, which is that providing that fundamental, yes, we talked earlier about prevention services, providing those services early make a huge, huge difference.

So it would be a giant step backwards to take the little bit of childcare that is now a part of the CalWORKS system, and root it in the Department of Education, with the community agencies who provide the access, the language, and

all that, move it back to the bureaucracy, move it back to the Department of Social Services, I hope, and pray, and plead with you not to do that.

Will Lightbourne put it very well this morning. He said, "don't just make a quick fix, don't just do it without asking yourselves why, what is it fundamentally underneath this."

And there's not a childcare advocate in this State that wouldn't roll up our sleeves and sit with you, individually and collectively, and try to figure out how we make this system better.

But a quick fix, back to the future, that's not the answer.

We were approached by many of the volunteers and staff members on the Trust Line and the issue of Licensed-Exempt Care. I want to say that we concur with many of those recommendations.

And I want to just finish going to Patricia Bates' comment, and she has been a wonderful advocate for families in Sacramento. You know, these recommendations are sort of all in and around what do we do to improve Licensed-Exempt Care? That's the care that's not regulated by anyone.

One recommendation says let's require 15 hours of health and safety training. Great idea, but there's no infrastructure to do that. It's not regulated. Who's going

to keep track of whether or not those folks get the training? Who's going to provide the training in the multiple languages that are required, because guess who our Licensed-Exempt Providers are? Guess who the men and women who provide care during the nontraditional hours, when many, many people on the Cal-WORKS program work, are? They don't speak English, they don't even often read English or Spanish. They speak Lao, they speak Vietnamese, they speak every language imaginable.

So these are big issues when we want to wrap around them.

And I have one suggestion. In terms of the whole enormous challenge of Licensed-Exempt Care, there is one back-to-the-future solution that we could look to. Until 1984 this State regulated all out-of-home childcare. If I cared for your children, if I cared for the children just from your family, or the children from five families, I had to be licensed.

We lost that in 1984. And since welfare reform, it has gotten really out of control, because now the notion of one other family could be 15 children, nieces and nephews, and you get very complicated situations.

So let's at least close that loophole, go back to regulating everyone who cares for the children from another family for money. I'm not talking about grandparents, but I

am talking about people who provide that professional service.

Don't cut the rates down to 50 percent of the ceiling, because let me tell you, in Fresno County that would mean that you would be providing that Hmong grandmother $11 a day to care for a child. That's not even as much as the kids working in the fast food stalls downstairs are making. That's not okay. Don't adopt that resolution.

Most of my other recommendations are there. I hope you hear my passion. I hope that you will agree to meet with us, locally. I know many of you are from San Francisco, that's where we're based. And we look forward to working with you.

This is a good beginning step, but it's not okay that something as important as our children's earliest years are left to be last, they are certainly not least.

I thank you.

COMMISSION CO-CHAIRPERSON HAUCK: Thank you very much.

Okay, we will conclude today. I want to thank the UC San Diego folks for the facilities, and Toastmasters for keeping our time. We thank all the public, who attended.

And with no further business, we're adjourned.

(Thereupon, the August 20th meeting and public hearing of the California Performance Review was adjourned at 4:02 p.m.)

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CERTIFICATE OF REPORTER

I, RONALD J. PETERS, a Certified Shorthand Reporter, do hereby certify:

That I am a disinterested person herein; that the foregoing State of California, California Performance Review Health and Human Services Public Hearing was reported by my staff and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties in this matter, nor in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 23rd day of August, 2004

Ronald J. Peters
Certified Shorthand Reporter
License Number 2780
Certified Manager of Reporting Services
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